U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 December 2002

Case No. 2001-LHC-1631

OWCP No. 6-173885

In the Matter of

ROLAND S. MUSE, SR.,
Claimant
v.

J. A. JONES CONSTRUCTION CO.,
Employer

TRAVELERS INSURANCE COMPANY,
Carrier

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party In Interest

Appearances:
Ralph Lorberbaum, Esq. and Paul Felser, Esq. for Claimant
Richard J. Harris, Esq., for Employer

Before:
RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER

This proceeding involves a claim for temporary total, temporary partial, and permanent partial disability from an injury alleged to have been suffered by Claimant, Roland S. Muse, covered by the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 948(a). (Hereinafter "the Act"). Claimant alleges that he injured his hip when he fell on rebar on November 6, 1987 while employed by Employer; and that as a result he is suffering from psychological injuries, including depression, and continuing hip condition.

The claim was referred by the Director, Office of Workers' Compensation Programs to the Office of Administrative Law Judges for a formal hearing in accordance with the Act and the regulations issued thereunder. A formal hearing was held on October 25, 2001. (TR).[1] Claimant

[1] EX - Employer's exhibit; CX- Claimant's exhibit; and TR - Transcript.

submitted forty-eight exhibits, identified as CX 1 through CX 48. (TR. at 37, 49). CX 1 through CX 28 and CX 33 through CX 43 were admitted without objection. (TR. at 39-40). CX 29 through 32 were initially rejected, however, later admitted. (TR. at 40-46; 60). CX 44, CX 46 and CX 47 were admitted over the objections of Employer (TR. at 48 49, and 51), and CX 45 was withdrawn after objection. (TR. at 47). Employer submitted thirty-one exhibits, EX 1 through EX 31. (TR. at 52). EX1, EX 2, EX 4, EX 11 through EX 13, EX 17 through EX 26, and EX 29 through EX 31 were admitted without objection. (TR. at 53-54). EX 3, pages 1-36, was excluded, however, EX 3, pages 37-44, was admitted. (TR. at 57-58). Initial objections to EX 5, EX 6 and EX 10 were withdrawn and the exhibits were admitted. (TR. at 59). EX 7 was withdrawn, except for page 5 which was admitted without objection. (TR. at 59). EX 14 was admitted without objection for the sole purpose of showing that as of April 7, 1997, the Claimant thought that he had an aggravation of a preexisting condition which resulted in a broken prosthesis in his right hip. (TR. at 67). EX 8, EX 16, and EX 27[2] were withdrawn. (TR. 62, 67,). EX 9 and EX 28 were rejected. (TR. at 64, 72). The record was left open until January 7, 2002 for briefs.

The findings and conclusions which follow are based on a complete review of the record in light of the argument of the parties, applicable statutory provisions, regulations, and pertinent precedent.

ISSUES

The following issues are disputed by the parties:

1. Whether Claimant's partial disability of the right hip is related to the 1987 work-related injury;

2. Whether Claimant's psychological condition is related to the 1987 work-related injury;

3. Whether Claimant's current condition is attributable to his original injury and/or hip condition, or whether he suffered an aggravation to his hip in 1988 and/or 1995 which would relieve the Employer of further liability under the Act;

4. The extent of Claimant's loss of wage earning capacity.

STIPULATIONS

At the hearing, Claimant and Employer stipulated that:

1. The Longshore and Harbor Workers' Compensation Act, (33 U.S.C. 901 et seq) applies to this claim.

[2] In its brief Employer states that they were unable to identify the source of EX 27 as required for admission (TR. at 69) and so withdrew the exhibit. (Emp. Brief at 2n.4).

2. The Claimant and employer were in an Employer-Employee relationship at the time of the accident/injury.

3. The accident/injury arose out of and in the scope of employment.

4. The date of the accident/injury is November 6, 1987.

5. The date when the Employer was advised or learned of the accident/injury was November 6, 1987.

6. Timely notice of injury was given the Employer.

7. The Employer filed a first report of accident on October 15, 1997.

8. The Claimant filed a request for compensation (claim) on August 12, 1997.

9. The Claimant filed a timely notice of claim.

10. Employer's notice of controversion was filed November 4, 1997.

11. a. Medical benefits under Section 7 of the Act are being paid.[3]
    b. Settlement under the Georgia Workers' Compensation Act was made in the amount of $45,000 to Muse.

12. No benefits income benefits [sic] were paid under the Longshore and Harbor Workers' Compensation Act.

13. The Claimant's average weekly wage was $498.77.

14. [Withdrawn]

15. a. Claimant returned to his regular employment on November 7, 1987.
    b. Since the date of the accident/injury, the Claimant has held the following positions at the listed salaries:

Job	Salary	Dates
J.A.Jones (Employer)	$498.77/ wk	11/6/87 to 1/25/88
Lockheed	varied	2/22/88 to 10/20/94

16. The nature and extent of the injury is as follows: Hip contusion; however, the parties disagree as to the extent and nature of the original injury. The Employer and Insurer paid for a total hip replacement, present psychological treatment and present orthopedic care for the hip.

[3] Subsequent to the hearing, Employer withdrew these benefits. *See* December 17, 2001 letter, to Claimant's attorney, submitted with Claimant's brief.

17. The accident/injury occurred at Kings Bay Submarine Base Dry Dock area in St. Marys, Georgia.

18. The accident/injury occurred November 6, 1987.

19. The issues to be resolved are as follows:
    1. Relationship between original injury and present disability;
    2. Extent of disability;
    3. Whether there is a loss of wage earning capacity under Section 8(c)(21);
    4. Right to future medical care;
    5. Attorney's fees; and
    6. Section 8(f) relief [reserved].

20. The Employer and Insurer are entitled to a credit under Section 3(e) of the Longshore and Harbor Workers' Compensation Act for all State Workers' Compensation benefits paid the Employee.

21. Permanent and total disability is not being claimed by the Employee at this time.

22. Claimant is entitled to temporary total disability benefits from January 26, 1988 to February 22, 1988.[4]

(JX-1).

DISCUSSION OF LAW AND FACTS

It has been stipulated that Claimant was injured on November 6, 1987 in an accident that arose out of and in the scope of employment. (JX 1 at Stip. 3, 4). It is undisputed that Claimant and Employer were in an employer-employee relationship at the time of the injury and that the Act applies to this claim. (JX 1 at 1, 2).

Testimony of Claimant

Claimant completed high school and then enlisted in the United States Army, security agency in 1966. (TR. at 121). He was on active duty for four years and had two tours in Vietnam in the field of military intelligence. (*Id*. at 121-22). When asked about injuries sustained while in the military, Claimant stated that he had stomach and skin problems, was shot in the chest once, scratched, beat up, and had shrapnel wounds. (*Id*. at 122). He also parachuted while in the military. (*Id*.). After leaving active service, Claimant joined the active Army Reserves and served until 1988. (*Id*. at 124). While in the Reserves, Claimant was required to attend weekend meetings and some three-day meetings. At annual training he was required to take physical training which included a timed run, repelling, climbing, sit-ups, push-ups and squat-thrusts. (*Id*.).

[4] This stipulation was added orally at the hearing. (TR. at 26-27).

He quit parachuting around 1977, because they began parachuting at night. (*Id*. at 124-25). Claimant's employment history also includes positions as a wildlife ranger for the State of Georgia, Game and Fish Law Enforcement Division, deputy sheriff for Camden County, and truck driver. (*Id*. at 122, 124, 127).

Claimant was employed for approximately two to three months as a carpenter with Employer, working on a dry dock being constructed at the Kings Bay Submarine Base in St. Marys Georgia. (TR. at 129). As a carpenter, his duties included pouring concrete through portions of steel grids made of rebar in order to make the floor of the dry dock. (*Id*.). A rebar was described as a round, solid piece of steel that gives concrete strength. (*Id*. at 130). At the time of Claimant's injury, the "mud slab" of the dry dock had already been poured, and they were working about five to seven feet off of the first slab of concrete on rebar steel. (*Id*. at 129). The rebar formed a mesh pattern, some vertical, some horizontal, like a checkerboard square, with plywood laid down the middle. (*Id*. at 131). On November 6, 1987, Claimant was working on this dry dock. (*Id*. at 132). According to Claimant, he "was walking on the cross rebar, and somebody had not tied one of the rebars, and it just rolled right up under [his] foot." (*Id*. at 133). In describing the accident, Claimant testified:

> And when I was walking across the rebar I felt one of them just roll completely under my foot, and I knew I was going to go down, so I dumped the boards [I was carrying], just pushed off of the boards to get them away from me. And when I went down, my shin caught on one of the rebars and it's from the top of the boot all the way up to my knee, just skinned it. And the worst part of it was, I'd come–I'd stepped – I'd went down over one of those towers that come up, the rebar, and my foot had bent– it had gone outside and bent almost backwards. And it was one of those pains that hits you right in the stomach. You just get sick to your stomach. And I was bleeding like a – like anytime you – the skin tears on your shin, it's very nauseating and it's – it makes you sick, and it hurts a lot.

(*Id*.). It was between five to seven feet between the concrete slab underneath and the rebar Claimant was walking on. (*Id*. at 133-34).

Claimant was asked to describe his injuries after this accident and testified:

> Well, my shin, of course, was very sore, and like I said, it bled something terrible. But I thought I was having problems with my knee and my hip. Because the knee had hit the rebars, what stopped me from keeping going any farther.

(*Id*. at 136). He received medical attention from Gilman Hospital in St. Marys. (*Id*. at 137). At that time Dr. O'Connell began treating Claimant. (*Id*.).

Claimant continued to work for Employer until January 26, 1988. (TR. at 138). His hip was getting progressively worse during this time. (*Id*.). He told his supervisor, about three days before he was let go, that he was having a problem with his hip, that it was getting worse. (*Id*.). He stated that, while he wasn't having problems with his actual job, "getting down in the hole and getting out of the hole" where he worked was very difficult. (*Id*.). Claimant also testified that his

job with Employer was strenuous and required him to be very agile. (*Id*. at 135). Prior to November 6, 1987, Claimant had no problem doing his job with Employer and no problem with his hip. (*Id*. at 136). He testified that he had to join the union upon beginning work with Employer and that"the union contract stated we would work six days a week Monday through Saturday at least ten hours a day." (*Id*.). He added that there was some overtime, sometimes resulting in 12 or even 14 hours a day. (*Id*.).

After leaving Employer, Claimant began working for Lockheed Missile and Space ("Lockheed") on February 2, 1988. (TR. at 142). With this employer, Claimant made different stages of the missile, adding hardware, electronics, and explosive devices. (*Id*. at 143). He testified that, physically, the job at Lockheed was about "50 percent or better easier" than his work for Employer. (*Id*. at 144).

In January of 1989, Claimant had a total right hip replacement by Dr. Fipp, paid for by Employer. (TR. at 145). He was out of work with Lockheed from January 10, 1989 through July 17, 1989 due to his hip surgery. (*Id*.). After the accident and the surgery, Claimant testified that he continued to have symptoms, discomfort and restrictions in his right hip. (*Id*. at 150). He has walked with a limp since the accident with Employer. (*Id*.). After the operation Claimant testified that he was depressed, that for six months he could not get out of his trailer. (*Id*. at 142). At that time he was referred to Dr. Mark Friedman for psychological treatment. (*Id*. at 141-42).

Claimant testified that he did not injure either of his hips or legs in any of his previous employment, including serving in the Army, the active Army Reserves, wildlife ranger for the State of George, deputy sheriff, or truck driver. (TR. at 127). In fact, he testified that prior to working for Employer, he had never sought any kind of medical treatment, advice or consultation regarding either of his hips, had never had any type of problem or difficulty with his hips, and his hips had not prevented him from doing any physical activity. (*Id*. at 128). Prior to his accident with Employer, he had not been told by anyone in the medical field that he had any type of medical condition in his right hip. (*Id*. at 129). He testified that, in all that time and in all those activities he participated in while a member of the Army and Army Reserves he did not have any problem or difficulty with either of his hips or legs and did not suffer any injury to his hips or legs. (*Id*. at 122-23). Claimant testified that, when he was in the Reserves up to November 6, 1987, he did not sustain any injuries to or have pain or difficulty with either of his hips and did not seek medical attention, tests, opinions or consultations about his hips until November 6, 1987. (*Id*. at 125-26). He further testified that he did not sustain or have any injuries to either of his hips from any other activities away from the Reserves prior to November 6, 1987. (*Id*. at 126).

While working at Lockheed, Claimant suffered from carpal tunnel syndrome and had both his right and left hand operated on. (TR. at 150-151). After the surgery on his hands, Claimant was sent to physical therapy, with Associated Rehabilitation Services, Inc., in August of 1995. (*Id*. at 151). Claimant testified that when it was time for him to leave the program he was given another test to show how much he'd improved. In addition to the arm exercises he was also asked to do leg lifts with both his left and right legs. (*Id*. at 152). Claimant testified that he protested about using his right leg but that he did try. (*Id*. at 152-153). After requesting the lightest setting, Claimant testified:

> She was still making the adjustment when I made the lift, and I heard a pop and got that flash of pain, and I thought I had broken my prosthesis.

(*Id*. at 153). There was an increase in pain, right at his hip, where his prosthesis is located. (*Id*.). He testified that it was three or four days until his pain was back to the normal level and that his hip was still popping. (*Id*. at 154). He further testified that his hip had never popped before. (*Id*.). At that point in time Claimant was still under restrictions from Dr. Fipp. (*Id*. at 153). At the time he filed his claim against Lockheed he still thought he had broken his prosthesis, however, he had not been to a doctor at that time and no doctor has told him since that it was broken. (*Id*. at 154). There has been no increase in his work restrictions since August of 1995. (*Id*.). No doctor has told Claimant, since August of 1995, that he needs surgery on his right hip or that he cannot work because of his hip. (*Id*. at 155). It is his understanding that he did not, in fact, break his prosthesis. (*Id*.). In fact, none of his doctors, since August of 1995, have told him that his right hip is worse since the incident during physical therapy described by Claimant. (*Id*.). Lockheed has not accepted his hip as part of their injury and have never paid for any of his treatment for his hip. (*Id*.).

Claimant testified that between the time he was let go by Employer and the date of the surgery in 1989 he did not suffer any new injuries or aggravations to his right leg. (TR. at 146). As far as Claimant knows, his hip did not play any part in his termination from Lockheed. He stated that if he had not been terminated by Lockheed and did not have problems with his hands, he would still physically be able to do his job at Lockheed. (*Id*. at 149). He has not worked anywhere since he stopped working at Lockheed in 1994. (*Id*. at 157). He currently cannot drive because of all the medication that he's taking. (*Id*.).

Claimant has resumed psychological treatment, and is presently under the care of Dr. Hurayt. (TR. at 155). He was referred to Dr. Hurayt after Dr. Friedman, his previous doctor, became ill. (*Id*.). When asked what he saw the doctors for, he replied:

> I've been told clinical depression. I've been told I have bipolar. I've been told– I don't know. When they put me in the hospital over on St. Simons, they brought me up on these medications and I go off them without coming down slowly, I'll die.

(*Id*. at 156). He stated that, in his opinion, it was the same kind of depression he was being treated for in the late 80s and early 90s; he felt it never stopped. (*Id*.).

Claimant agreed that the only doctor that treated him from 1991 until 1994 was Dr. Dargon, before he went to see Dr. Lemel for his carpal tunnel. (TR. at 196). At the time he was terminated from Lockheed, he still had the same limited range of motion in his hip he had had since the operation, was able to drive, and was not taking any medication for his hip pain. (*Id*. at 197). At that point he had no popping or clicking of the hip and had no problems with his hip replacement. (*Id*. at 198).

Testimony of Terry Smith

Terry Smith is employed by the Georgia Department of Veterans Service in Brunswick Georgia. (TR. at 77). In addition, he has an office in Camden County. (*Id*. at 78). His job is to counsel veterans, widows and dependents of veterans, assisting them with any kind of compensation claims, pension claims, educational claims, and health benefits. (*Id*.). Claimant came in to see Terry Smith, in his Camden County office, in order to discuss and receive help with a compensation claim for injuries received in the military on July 19, 1999. (*Id*. at 79, 91). Mr. Smith's Camden County office, at this time, did not contain a typewriter or computer. (*Id*. at 79).

Due to Claimant's carpal tunnel syndrome, and the braces he wore for the condition at this time, and the fact that he did not have his glasses with him, Claimant asked Mr. Smith to fill out the required forms for him. (TR. at 80). Mr. Smith testified that his conversation with Claimant was "scattered." (*Id*.). Since there was no typewriter or computer available, Mr. Smith filled in the form by hand and was going to transfer it in a typewritten form later. (*Id*. at 81). Claimant signed the form, in his presence, however, because he was going to transfer it to a typewritten form, the form signed by Claimant was blank. (*Id*. at 82). When asked if there was a possibility that, in taking down the notes and transposing them over to another form later, he may have misunderstood any of the information from Claimant, he replied:

> Well, there's always a possibility of that. Like I said, he was talking about a lot of different things and they were running into each other and – and as far as I knew at that particular point, everything I had written down was– was what he was claiming. I did put the, you know, the form in front of him, but he didn't have his glasses or anything, so he really couldn't see– he just went ahead and signed the form and– and I typed it up when I got back to the office and forwarded it out to him.

(*Id*. at 83). Mr. Smith testified that Claimant did not have a chance to review the typewritten version of what was sent out before it was sent. (*Id*.). Mr. Smith stated "it was difficult to decipher everything that [Claimant] was saying." (*Id*. at 86). He also testified that, normally, he gets a copy of all the letters sent out to the veterans they represent, however, in this case they never got copies of the VA letters. (*Id*. at 89).

Testimony of Mrs. Gloria Muse

Claimant and Mrs. Muse have been married for twenty years. (TR. at 99). She testified that, prior to 1987, Claimant was very active and she did not notice anything psychologically or emotionally bothering him. (*Id*. at 99-100). After his hip injury in November of 1987, Claimant's wife testified that he had unexplainable mood swings and an increased temper, in her opinion caused by the injury which "took everything away from him." (*Id*. at 100). From what she has observed Claimant suffers from depression and anxiety. (*Id*. at 101). Claimant's wife also testified that Claimant's hip got progressively worse after his accident with Employer. (*Id*. at 113). Further, she testified that after an incident in work-hardening, Claimant's hip began popping or clicking although she has only heard it twice. (*Id*. at 116).

Medical Evidence

Dr. O'Connell

On August 1, 2001 Dr. Michael J. O'Connell[5] was deposed. (CX 7). Referring to his notes, Dr. O'Connell testified that his first visit with Claimant was on November 10, 1987 when he was complaining of pain in his right hip. (CX 7 at 5); (CX 6 at 1). Dr. O'Connell was the first doctor Claimant saw for his hip pain after his accident with Employer. (CX 6 at 1). Claimant reported his work accident and denied previous problems. (CX 7 at 5). Claimant reported that he has had pain in his right hip area since that time and is unable to walk without a limp and pain. (CX 6 at 1). He reported no previous injury with his hip. (*Id*.). Dr. O'Connell's examination showed pain with range of motion. (*Id*.). The x-rays showed "degenerative changes of the right femoral head with flattening and some cyst formation and spurs. The left hip appear[ed] normal." (*Id*.). Claimant continued returning to Dr. O'Connell with complaints of pain, however, Dr. O'Connell wanted to hold off on doing surgery due to Claimant's young age. (*Id*. at 1-2).

Dr. O'Connell was asked to describe the actual injury Claimant suffered on November 6, and replied that, he had noted that Claimant "fell while working on some rebar coming down twisting his right leg." (CX 7 at 7). He agreed that the degenerative changes showed by x-rays would not have been caused by that injury. (*Id*.). Dr. O'Connell agreed that, from Claimant's first visit, he recognized the need for eventual surgery, explaining "he had degenerative changes.[6] He had cystic changes. We know that these become progressive, and that, eventually, these type of people that have this problem will need a replacement to relieve their symptoms." (*Id*. at 8-9). He noted a discussion with Claimant regarding the fact that he "is going to have a long term problem."[7] (CX 6 at 1). He stated that the x-rays taken in November, February and April showed the same type of changes (CX 7 at 13). He further testified that he referred Claimant to

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[5] Dr. O'Connell is board-certified and his curriculum vitae is in evidence at (CX 8). *See also* (CX 7 at 5).

[6] Dr. O'Connell was asked to define Claimant's condition and explained that there are several different sub-groups of arthritis, including necrosis, which he defined as:

> Necrosis, avascular or aseptic necrosis is changes that occur when there's blockage or breakdown of the blood vessels, within an area, and it doesn't get its normal blood flow to it with its normal nutrients, and the bone deteriorates in that area.

(CX 7 at 10). When asked about the causes of aseptic necrosis, Dr. O'Connell agreed that excessive drinking of alcohol can be very significant in connection with the development of necrosis. He further testified:

> We do not know specifically what causes aseptic necrosis of the hip. We do know that there's an increased incident in aseptic necrosis of the hip with people who have excessive intake of alcohol, diabetics, and people who take steroids. We know that those particular groups have a higher incidence, but we truly don't know – we don't know what causes aseptic necrosis, but we know that alcohol is – these people do have a higher incidence of aseptic necrosis of the hip.

(CX 7 at 45). The steroids are primarily oral. (CX 7 at 45-46).

[7] Claimant and his wife dispute the fact that they were told of this long-term problem by Dr. O'Connell. (TR. at 100-106).

Dr. Fipp, who was doing total joint replacements full time. (*Id*. at 14). Further, he testified that, considering Claimant's young age he anticipated further replacement after the first. (*Id*.).

On February 2, 1988, Claimant returned to Dr. O'Connell. (CX 6 at 2). Dr. O'Connell noted that Claimant felt much better in the hip area since stopping the hanging at work[8]. He also noted "He is supposed to go the reserves and I do not want him to do the 2 mile run or any other running as I think this is detrimental to his hip area." (*Id*.). Dr. O'Connell noted that Claimant's x-rays did not show any further deterioration of the right hip on February 9, 1988. (*Id*.).

On April 12, 1988, Claimant returned to Dr. O'Connell reporting pain in his right hip that went all the way to his knee. (CX 6 at 2). Dr. O'Connell still wanted to wait on surgery, however noted that Claimant wanted to be able to do high impact activities, such as running in the Reserves. (*Id*.). Dr. O'Connell writes that he does not think Claimant "will ever return to this running status without severe pain whether or not he is treated surgically or non-surgically at this point." (*Id*. at 3). On April 26, 1988, Claimant returned to Dr. O'Connell. (*Id*.). Claimant reported that the use of a cane helps his pain more than anything else. Claimant also reported having a hard time doing his job because it requires a good deal of walking. Finally, Claimant reported that he is "hurting now down also to his right knee and he hurts when he sits now." (*Id*.). The x-rays on this date show changes, Dr. O'Connell reports: "I can't really tell if there is any cracking through the cystic areas, although as before there is an offset on the femoral head where it has depressed." (*Id*.). On July 5, 1988, Dr. O'Connell writes: "He has to go to reserve camp. I gave him a note saying he could not do any running, calisthenics, or other physical activities such as that." (*Id*. at 6; 9). On a disability certificate dated August 23, 1988, signed by Dr. O'Connell, it states "Patient's condition is operable. I feel his work status will improve post-surgery." (EX 5 at 25). Claimant testified that, although Dr. O'Connell's notes indicate that he had been doing some running, he was not. (TR. at 187).

On May 23, 1989, Claimant returned to Dr. O'Connell after having his right total hip arthroplasty done in January. Dr. O'Connell reported that Claimant was doing well with his replacement, although Claimant "states that while he was in the hospital he got midsternal type pain." Dr. O'Connell also noted that Claimant was reporting being "psychologically down due to his time off and his problem with his hip and thinks he may need help...". (CX 6 at 6). On September 29, 1989 Dr. O'Connell wrote a letter with recommendations for Claimant to Mr. William Sabo. (*Id*. at 11). It included psychiatric evaluation and treatment and other physical therapy and adjustments in his environment. (*Id*).

On January 23, 1990, Claimant again returned to Dr. O'Connell reporting pain in his right thigh and low back. Dr. O'Connell noted: "On examination today he has decrease in the muscle mass of the right buttocks, hip and thigh. His range of motion is good." (CX 6 at 7). Claimant was sent to physical therapy at this time. (*Id*.). On April 3, 1990 Claimant returned to Dr. O'Connell and discussed his therapy, which he reported seemed to help. (*Id*.). On July 10, 1990, Claimant returned to Dr. O'Connell complaining of pain in the area of his right hip and anteriorly and posterolaterally, relating it to work. Dr. O'Connell felt the patient had overuse syndrome in

[8] Claimant had reported that his biggest problem occurred when he hung on the wall on safety straps. (CX 6 at 2).

the soft tissue and no change in hip replacement. (*Id*. at 8).

Claimant's last visit was March 10, 1992. (CX 7 at 21). At that time, Claimant told Dr. O'Connell he felt he was doing well with his hip although he did have to use his cane to walk over about 60 feet. (*Id*.). He had good flexion, extension, abduction, and limited internal/external rotation. Dr. O'Connell stated that this was a frequent occurrence in hip replacement patients after surgery:

> With hip replacement surgery, some people go from getting back full range of motion to some have limited range of motion. His was one of the ones with some limited range of motion still.

(*Id*. at 22). He stated at that time, Claimant was able to work, his hip was stable, his weight was down and he had finished with his psychological counseling and was told to come back as needed. (*Id*. at 23-24).

Dr. O'Connell was asked if, after a review of his notes, he would be able to say when the symptoms from Claimant's fall in November of 1987 would have resolved themselves, and when the necrotic condition would have taken over. (CX 7 at 24-25). He replied:

> Well, the problem he had with his hip and the bone itself, the arthritic condition, preexisted his fall. I really have no way of estimating a time if he did not have that, whether the fall would have hurt his hip, even at what time sequence that would be. I feel it's more of an aggravation of a preexisting disease. I can't really put a time on it.

(*Id*. at 25). He was asked to review a September 26, 1988 letter from Dr. Fipp which stated that Claimant's fall was a temporary aggravation of his preexisting aseptic necrosis of the right hip. (*Id*.). He agreed that it was an aggravation of a preexisting condition, but he couldn't put a time frame on how long it would or wouldn't last. He did state that he felt, as Dr. Fipp said, that there was a preexisting condition. (*Id*. at 25-26). When asked, Dr. O'Connell agreed that Claimant's accident of November 1987 was a precipitating cause of the pain in his hip. He could not categorically state that without the fall, Claimant would have had pain although he anticipated that it was likely. (*Id*. at 36).

Dr. O'Connell was asked if the injury Claimant had in November 1987 had any effect on the natural progression of his preexisting condition. He replied:

> Again, I think that's very difficult. When people are developing such a problem, you already have developed it to a certain level, before you start having symptoms. Whether the symptoms start just one day when you are lying in bed, or whether all of sudden the symptoms come on when you have had a [sic] injury, it's very difficult to say. I don't think that the fall itself changed the disease process.

(CX 7 at 26). The following exchange then occurred:

Q: It didn't really cause any permanent, residual impairment. It was just as Dr. Fipp said, temporary aggravation of that condition?

A: Again, I don't know if I can use the term temporary. I can't put a time limit on how long you're going to have the pain, after something like that happens.

Q: In so far as the basic condition itself, it didn't cause that?

A: It did not cause the basic condition of the hip.

(CX 7 at 26-27). Dr. O'Connell was also asked about Claimant's date of maximum medical improvement. (*Id*. at 27). He replied that Dr. Fipp would be the one to answer that. (*Id*.). He thought that it would at least be a year after surgery. (*Id*. at 28).

When asked if, in his opinion, the incident of November 1987, hastened the need for Claimant's surgery, Dr. O'Connell replied:

> Well, he became symptomatic after that, and continued with his symptoms, and then needed the surgery. As we've discussed, his disease was preexisting, but it's the symptoms of the disease that bring you to the surgery.

(CX 7 at 39-40). He agreed that the surgery was not immediate and that, due to Claimant's age, he tried to avoid the surgery as long as possible. (*Id*. at 40). The following exchange then occurred:

Q: Given the condition of the necrotic condition of the hip, when you first saw it on x-ray there November 10th or so of 1987, would you have concluded, at that point in time, based on what you saw in the x-ray, that it was likely that he would have had some pain in the hip, within the very near future from that condition, if he had not had this injury?

A: Well, as I stated earlier, I had no way of putting when and if it would happen, that certainly the disease process was there. Some people will go prolonged periods of time and never know they have it until the first symptom appears. We never know we had the disease until the first symptoms appear.

(*Id*. at 41). He stated that he would probably agree that sooner or later Claimant would have had symptoms. (*Id*. at 41-42). Finally, Dr. O'Connell was asked:

Q: Assuming that he was asymptomatic in the hip, prior to this accident that happened in November of '87 that happened on the job with my client, is there anything that would indicate that this accident had any effect on his hip, other than the fact he may have been asymptomatic before that and became symptomatic after that?

A: No.

(*Id*. at 46).

Dr. George Fipp

In a letter dated September 26, 1988, to the insurance company, Dr. George J. Fipp, M.D., P.A.,[9] reported on his examination of Claimant. He met with Claimant per the company's request. (EX 17-1). For approximately the last 10 to 12 years of his practice, Dr. Fipp performed only total joint implants. (CX 14 at 7). After reviewing the history of Claimant's accident and condition, reviewing x-rays and performing an examination, Dr. Fipp writes the x-rays show "aseptic necrosis of the right hip with continuing collapse since the first x-ray of November 7, 1987." (EX 17 at 1-2). He writes:

> I feel this patient has aseptic necrosis of the right hip. I feel the fall was a temporary aggravation of a pre-existing condition.

(EX 17 at 2). His office notes accompany this letter. (*Id*. at 3-8). *See also* (CX 13 at 12-13). He then opined that Claimant needed surgery on his right hip. (EX 17 at 2).

Dr. Fipp testified, and stated in his letter, that he felt Claimant's aseptic necrosis of the hip was a preexisting condition. (CX 14 at 11). He stated that for a trauma to progress to avascular necrosis, a period of time, a few months, is needed whereas Claimant's x-rays, taken the day after his accident, showed the condition. (*Id*. at 12). He also stated that while the amount of trauma it takes to cause avascular necrosis from trauma alone "is probably really not known, but it does not have to have enough trauma to have a fracture with it. It can have a, quote, bruise or a jolt to the hip," the condition would take a certain period of gestation to develop to the point seen on the November 7th x-ray. (*Id*. at 13).

When asked to describe avascular or aseptic necrosis- different names for the same condition- he testified:

> It's most probably categorized as a disease. Aseptic means without infection. Necrosis means death. Avascular necrosis means without vascularity of blood supply. Necrosis, again, means death. The ball of the hip dies. If you look at it under the microscope, the cells become dead. The etiology, or what causes it, it's multifactorial, with a few cases being idiopathic, meaning we don't know why. In very few cases it's associated with trauma. In a great many cases it's associated with alcoholism, and in a few cases it's associated with blood dyscrasia, liver diseases, et cetera, and in a few cases with immune situations, as those who are getting transplant organs and are under cortisone medications for those other diseases.

(CX 14 at 10-11). In addition, Dr. Fipp stated that one of the etiologies of this disease is

[9] Dr. Fipp's credentials are described. (CX 14 at 6-7).

steroids- cortisone, prednisone, all the cortisone derivatives. (*Id*. at 11). He also agreed that alcohol intake is a very severe risk factor and that Claimant's wife had explained her husband's heavy drinking habits on November 18. (*Id*. at 18-19). He testified, however, that "I don't think we know, once you have the disease, whether continued drinking makes it worse." (*Id*. at 21).

Dr. Fipp agreed that, from the notes he reviewed, Claimant's condition was asymptomatic prior to November 1987. (CX 14 at 41-42). When asked: "Do you have an opinion as to whether or not the incident of November 1987 acted like a triggering device so that from that day on, through the time for surgery, [Claimant] now had symptoms in his right hip?" He replied: "That's a possibility." (*Id*. at 42-43). He stated that he could, however, rule out the possibility of the November 1987 incident as causing Claimant's disease. (*Id*. at 43). He stated he could not, however, rule out the possibility that the incident of November 1987 caused the symptoms that he presented to him and the need for surgery. (*Id*.). He could rule out the incident as the cause of the need for surgery, however. (*Id*. at 43-44). He was asked "Can you rule it out as a contributing factor?" and replied "Only as a temporary increase in these symptoms, or initial symptoms." (*Id*. at 44). He agreed that prior to November 1987, according to what he understood, Claimant had no symptoms, no indication that he had ever been told that he needed surgery to his right hip, or that his right hip kept him from doing any activity. (*Id*.).

On November 28, 1988, Claimant returned to Dr. Fipp. On this date the surgery was discussed as was Claimant history, including alcohol consumption. Dr. Fipp stated "I also told [Claimant and his wife] that continued consumption of alcohol could easily incite disease in his other hip, increase his weight gain and of course expense." (EX 17 at 3). On November 28, 1988 Claimant's wife gave a history of "half a gallon of bourbon per week and also drinks beer...". (CX 13 at 1). Dr. Fipp opined that Claimant's knee problems are probably coming from his hip. (*Id*.).

On January 6, 1989, Claimant visited Dr. Fipp to discuss his surgery and have x-rays. (EX 17 at 4). Claimant's total hip replacement was performed on January 11, 1989. (*Id*.). In a hospital admission slip with history and physical dated January 10, 1989, Claimant prepared for his surgery. His diagnosis was noted as: "Alcoholism; aspetic necrosis, right hip; obesity." (*Id*. at 5). In an operative report dated January 11, 1989, Dr. Fipp noted that Claimant's preoperative and postoperative diagnosis was the same, aseptic necrosis, right femoral head. (*Id*. at 6). He then recorded the details of the operation. (*Id*. at 6-7). In a discharge summary dated January 24, 1989, Dr. Fipp noted that Claimant's total hip replacement on January 11 went well, that he did well postoperatively. (*Id*. at 8). He was given written instructions and scheduled a follow-up visit. (*Id*.).

Claimant returned for a post operative follow-up with Dr. Fipp on February 6, 1989. (EX 17 at 4). In this office note dated February 6, 1989, Dr. Fipp writes:

> Patient had a total hip on the right January 11, 1989. He states he is asymptomatic and doing well. He has good motion. He will continue non-weight bearing and return in 2 weeks.

(*Id*.). In a note dated March 13, 1989, Claimant saw Dr. Fipp who noted Claimant was doing

well, no discomfort in his hip. (CX 13 at 2). In a note dated April 24, 1989, Claimant again saw Dr Fipp. He writes that Claimant has no complaints about hip other than "he has a little tiredness or heaviness posteriorly when he sits too long." His x-rays showed no complications. (*Id*.). Dr. Fipp last saw Claimant on June 16, 1989. At that time Claimant reported no discomfort and walked with a slight limp. He wanted to go back to work on July 9, and Dr. Fipp allowed that with some restrictions as to climbing, lifting, and being allowed to use a cane. (CX 14 at 23); (EX 17-4)(office note).

Dr. Robert S. Lykens

On August 29, 1990, Dr. Robert S. Lykens reviewed Claimant's history and examined Claimant and his x-rays, stating that Claimant walked with a limp and had excellent range of motion, although not flexion. (CX 12 at 1). His impression was that Claimant was doing very well, and "[t]he ingrowth components appear to be well placed and the hip is stable." (*Id*.). The purpose of Dr. Lyken's examination was to assess the durability of the hip replacement given Claimant's age and size. After commenting that Claimant needs to lose weight, Dr. Lykens writes:

> In summation, it appears that this man's total hip replacement has ben a success. However, because of his relatively young age and size it is quite likely that he will need two or perhaps even more of his hip [replacements] during his normal life span.

(CX 12 at 1-2).

Dr. Doreen Dargon

Claimant first saw Dr. Doreen Dargon on December 6, 1993. Dr. Dargon noted: "Roland Muse had a history of aseptic necrosis of his hip with subsequent hip replacement. Squatting is difficult and painful and should be restricted." (CX 24 at 6). In an office note dated December 14, 1993, Dr. Dargon noted that Claimant presented to the office for a physical examination. Dr. Dargon's impression was status post total hip replacement, pipe smoker and her plan was to have baseline labs drawn and EKG, chest x-ray and stress test ordered. (EX 4 at 3). *See also* (CX 24 at 7- 9).

In a patient report dated August 29, 1995, Dr. Dargon wrote that Claimant appeared with complaints of constant and aching lower back pain with no radiation. He reported that the pain began after doing physical therapy. It is noted that Claimant complained of "muscle aching in his lower extremities [that] has been increasing since a few days ago. The pain occurred when exercising." (EX 24 at 4). After an objective exam of his chest, cardiovascular, abdomen, peripheral vascular, and back, her plan was to prescribe medications and rest and return if symptoms worsen. (*Id*.).

On September 11, 1995 Dr. Dargon reports that Claimant appeared:

feeling sad, helplessness and inability to relax which began gradually several

> months ago. Risk factors for suicide include financial setback. Denies suicidal ideation and suicidal intent. The patient presents with recurrent and intermittent lower back pain with no radiation. The pain occurred when exercising. The symptoms are partially alleviated by resting and analgesics. The patient suffered no injury but presents with pain and limited movement of his right hip. He has a right hip prosthesis and states that physical therapy has caused pain in hip which was not present prior to exercise.

(CX 24 at 24). On September 10, 1996, Dr. Dargon wrote that Claimant "has been unable to perform duties as a mechanic as of October 20, 1994, because of restrictions on bending, lifting and kneeling." (CX 24 at 26). However, there is no office note from that date and no mention of such a change in condition in the notes submitted.

Dr. Joseph Proctor

In a physical examination record dated February 10, 1988, from Dr. Joseph Proctor, Claimant lists his condition as "being treated for cyst right hip due to fall only minor ocs. discomfort. (EX 18 at 1). The doctor's handwritten notes are illegible. (*Id*). In an employee medical report entitled release to duty exam, dated October 26, 1988 and signed by Dr. Proctor, it states no climbing and standing to level of tolerance. (*Id*. at 3). Under objective complaints, Dr. Proctor stated:

> ...Dr. Michael O'Connell in St Marys, GA ... told [him] he had "a cyst" on his right hip. He was placed on Motrin and was seen by me for a Lockheed pre-employment physical on 2/10/88, at which time he had only minimal discomfort in the hip and made no major issue of this. Physical findings at the time were unrevealing, and he was cleared for his job. However, he subsequently developed more severe and prominent pain in the hip and was referred by Dr. O'Connell to Dr. George Fipp, another orthopedist in Jacksonville, FL for evaluation. He says that Dr. Fipp told him that he would probably need surgery and told him he had a diagnosis of avascular necrosis of the head of the femur. Dr. Fipp was contact[ed] by me today, and he confirmed this diagnosis. However, he states that he told the patient that it was unrelated to his accident. Nevertheless he feels he will most likely need surgery in the relatively near future. ...

(*Id*. at 4). Dr. Proctor's objective examination showed a prominent limp with the right leg, with prominent pain of medical rotation or prominent flexion. His assessment was avasular necrosis of the head of the right femur. His plan was: "Patient will be advised to be placed on restrictions which would prohibit him from climbing, and he will be allowed to stand to his level of tolerance. It he cannot tolerate this, then he will be confined to bench or desk work only." (*Id*.). Finally, on an employee medical report dated July 6, 1989, Dr. Proctor writes, "may return to work with following limitations, not to climb ... [illegible] no prolonged walking." (*Id*. at 9).

Dr. Mark Lemel

On September 5, 1995 Claimant saw Dr. Mark Lemel,[10] his treating physician for carpel tunnel syndrome. (CX 26 at 12). At that time Claimant was upset and complaining of pain in his back and legs exacerbated by the walking done in physical therapy. (*Id*.). He stated he was willing to work on an exercise bike and was encouraged to do so. (*Id*.). Dr. Lemel stated that he encouraged Claimant to see Dr. Fipp again about an evaluation for his hip which appeared to be bothering him more. (*Id*.). Dr. Lemel also noted Claimant's "mental anguish" and stated Dr. Dargon "will see about restarting him on some Prozac." (*Id*. at 12).

On September 12, 1995 Claimant returned to Dr. Lemel. At that time Dr. Lemel wrote:

> Mr. Muse still continues to be unable to sleep and still has diffuse pain. His physical examination, however, does not support this. We are going to ask him to see Dr. Mark Freeman in St. Simon's, Georgia. I believe he has stress related depression. This may be arising out of his bad circumstances regarding his job. We will also request that he be seen by Dr. Dargon for anti-depressant medication.

(CX 26 at 13). Again complaining of pain, Claimant returned to Dr. Lemel on November 17, 1995. At that time Dr. Lemel wrote:

> His main complaint centers about his right hip. We have written a letter to Dr. Bahri attempting to get him in for a follow up visit. He feels that it is related to some exercises he did at the work hardening. I believe that he needs to be evaluated for this pain before any determination of causality is made.

(*Id*. at 14);(EX 22-12). On January 19, 1996 Dr. Lemel noted that Claimant was still having problems because of his hip and states that "we have again asked that he be seen by the Drs. Bahri for this." (CX 26 at 14). On February 23, 1996 Claimant returned to Dr. Lemel who wrote:

> He is having some problems with his hip and has been on crutches for one month and this has exacerbated the symptoms in his hands somewhat.

(*Id*.). He did not change restrictions and anticipated maximum medical improvement for Claimant's hands at the next appointment in 6 weeks. (*Id*.). On April 9, 1996 Claimant returned to Dr. Lemel who noted: "He is having a lot of problems with his hip and with depression, which we will continue to try and get straightened out." (*Id*. at 15).

Dr. Georges El-Bahri

On January 31, 1996, Claimant was seen by Dr. Georges El-Bahri[11] of Bahri Orthopedics & Sports Medicine Clinic, P.A. (CX 15 at 1). At that time he filled out a Health Status

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[10] Dr. Lemel's curriculum vitae is in evidence at CX 27.

[11] Dr. Bahri's curriculum vitae is in evidence at CX 17.

Statement and his diagnosis was "Right THA." (*Id*.). Claimant's chief complaint was right midthigh pain. (*Id*. at 2). Claimant reported that he sustained an injury on August 24, 1995, while in his work hardening program, doing leg lifts. (*Id*.). Dr. Bahri reported that Claimant stated his pain was "localized over the anterior midthigh and is made worse with extending [sic] sitting or standing for more than thirty minutes." He also notes pain pills, aspirins and heating pads help and that Claimant has no night pain. Popping and "giving way" were also discussed. (*Id*.). X-rays were taken and "reveal[ed] a PCA total hip arthroplasty in satisfactory alignment." (*Id*. at 3). His impression was status post right total hip arthroplasty and his plan was to continue ambulating nonweightbearing and return for a recheck in one month. (*Id*.).

On March 6, 1996, Claimant returned to Dr. Bahri. (CX 15 at 4). At that time Claimant reported continued aching in his right midfemur, rating it a 5 on a scale of 1-10 when resting and higher when weightbearing, with no night pain. Upon examination Dr. Bahri noted good passive and active range of motion with normal neurocirculation. Claimant was "tender over the posterior aspect of the greater trochanteric area." (*Id*. at 5). His plan was to order a "CBC with differential and sedimentation rate"; start physical therapy; continue Tylenol #3 and Advil; and schedule a return for a recheck. (*Id*.). On March 12, 1996 Claimant had a physical therapy evaluation and plan of care at Bahri Physical Therapy. At that time he described his injury, again, as occurring during work hardening in August of 1995. (*Id*. at 6; 8-9)(progress notes, plan of care, and therapeutic goals with Bahri Physical Therapy).

On June 27, 2001, the deposition of Dr. Georges El-Bahri was taken. (CX 16). Claimant was referred to Dr. Bahri by Dr. Lemel. (CX 16 at 6-7). Dr. Bahri states that Claimant reported injuring himself on August 24, 1995 while performing leg lifts in a work hardening program. (*Id*. at 7-8)(Dr. Bahri is merely testifying from notes, he does not personally recall Claimant). He stated that on this date he did not arrive at an opinion as to what was the cause of his popping and the hip pain. (*Id*. at 11). The following exchange then occurred:

> Q: If a person is post total hip replacement, and has a prosthesis in place, I'm assuming, then, from your report, that it's very possible to reinjure that site through excessive exercise; or because somebody does something with some type of machine, that maybe they shouldn't do, or put too much pressure on it, or something, any number of different scenarios could arise that would cause you to reinjure an operation site such as a total hip replacement area?
>
> A: Correct.
>
> Q: Is it possible, in that situation, for there to be an audible sound occur [sic]? Mr. Muse gave a deposition a number of years ago in which he said that when he was doing this machine, doing some leg lifts, or with some type of hydraulic type of equipment, he said, 'There was a big pop and I had a lot of pain.' Is it possible that you could have some sort of audible sound that would come from the device, or would there be muscles or something involved that could pop, that maybe you hadn't used before, that would cause this all of a sudden to become symptomatic?
>
> A: It is possible to have a pop or a sound of a pop and experience pain afterwards.

(CX 16 at 14-15).

Dr. Bahri stated that, because the x-rays on Claimant's first visit were taken by his office, there would not be an x-ray report, as he just read them there. (CX 16 at 33). The only x-ray he looked at would be the one he took. (*Id*. at 38). He stated that, if he had seen loosening or a break in the prosthesis he would normally have put it in his notes. (*Id*.). He stated that Claimant's prosthesis was in satisfactory alignment. (*Id*. at 33). He found no specific evidence of new damage to Claimant's right hip aside from Claimant's complaints of popping and pain. (*Id*.). He agreed that his examination showed no bleeding, broken bones, torn muscles, torn ligaments or anything wrong with Claimant's prosthesis. (*Id*. at 37). He heard no popping and clicking in Claimant's hip and found no objective evidence regarding an injury to Claimant's hip in 1995. (*Id*. at 41-42).

When asked for his opinion regarding the incident in work hardening and whether it had an effect on Claimant's right hip, Dr. Bahri replied: "It is possible. I didn't see him. I did not follow him long enough to have a firm opinion regarding the injury." (CX 16 at 17). When asked if, based upon the other doctors' reports, he was in the position to say that Claimant had some injury to his hip that arose out of his work hardening experience, he replied:

> No, I'm not going to venture to give an opinion on a complicated issue when I saw the man only twice. I tried to initiate a treatment and workup, and actually I did, and he didn't come back. So I [do] not have an opinion on his injury. It is correct, as stated to me, that he had, and I had no reason not to believe him, that he did have an injury in August of '95, and this is what brought him to my office in January 1996 ... I did not rule [the possibility that he reinjured his hip] out or in. It is possible. I mean a lot of things are possible, and I do agree with you that this is what brought him most likely to my office. But beyond that, I cannot give a medical opinion.

(*Id*. at 24). After being asked a long and complicated hypothetical, incorporating Claimant's account of an incident at physical therapy, and being told to discount the "reasonable degree of medical probability" standard and assume several things, such as that Claimant's hip stabilized, Dr. Bahri stated:

> Well, the problem is, you asked me a question with a lot of addition to it. I don't know if his hip was stabilized up to this injury. I don't have enough history on this patient. I don't have enough medical records. But assuming this is correct, I do agree that there was an intervening injury at that time, based on his history and what brought him to my office.

(*Id*. at 31-32). Assuming that Claimant's subjective complaints are correct, Dr. Bahri would not rule out the possibility that he reinjured his hip as a result of this physical therapy session. (*Id*. at 42). He is not, however, giving an opinion as to whether, if Claimant did reinjure his hip, it was temporary or permanent. (*Id*. at 42-43).

Dr. William Campbell

In a letter dated August 19, 1997, Dr. William N. Campbell[12] discussed his second opinion of Claimant's condition. He writes:

> As you are aware, Claimant underwent total hip arthroplasty by Dr. Fipp in January of 1989. The surgery was subsequent to the development of avascular necrosis of the right hip which according to Dr. Fipp's records is probably precipitated by the patient's alcohol intake. The patient's recovery from the total hip arthroplasty was fairly uneventful. He was seen in 1995 by Dr. Lemel who performed surgery on the right hand. He states that during his rehabilitation, he was performing leg lifts in a work hardening program which resulted in sudden pain within his right hip. This has been going on for over a year. ... The patient states that he has constant pain in the hip which he describes in the posterior part of the thigh and buttocks. He says that he has popping and clicking which is painful. He occasionally has numbness and tingling of the legs with the right being greater than the left. He says he has to ambulate with a cane. ... The patient denies any thigh pain or any pain in the groin area. ...

(EX 23 at 1). In discussing Claimant's physical examination, the doctor noted that Claimant uses a cane to walk. He also noted that an examination of Claimant's hip reveals fairly good strength and range of motion, and that he heard no popping or clicking. (*Id*. at 2). He repeated x-rays of the hip and stated: "There is no sign whatsoever of loosening of either the acetabulum or femoral component." (*Id*.). His impressions were: "status post total hip replacement, right, in 1989; popping and pain of the hip and posterior aspect of the buttocks with etiology unknown; psychophysiologic musculoskeletal disorder; and probable history of substance abuse to include extensive alcohol use." (*Id*.). He wrote:

> The patient did not receive well my recommendation for no additional surgery. I have explained to him that the hip is well seated and shows no sign of loosening. I have told him that there is not a good chance that revision surgery will ameliorate the patient's present complaints. I have no doubt that the patient is suffering from some back pain as a result of his abnormal gait and apparent limping. However, treatment is not necessary.
>
> At the present time, I do not think there is any need for additional treatment. I do feel that the patient has reached maximum medical improvement. As an aside, I showed the x-rays to my associate, Dr. Lynn Norman, and he concurred with me about the condition of the total hip prosthesis.

(*Id*.).

On August 30, 2001, Dr. Campbell was deposed. (CX 19). As discussed *supra*. Dr.

[12] Dr. Campbell's curriculum vitae is in evidence at CX 20.

Campbell examined Claimant on August 19, 1997. (*Id*. at 6). At that time he reviewed Claimant's medical records including those from Dr. Fipp, Dr. Lemel and Dr. Bahri. (*Id*. at 7). He also did a physical examination of Claimant. (*Id*.). When asked to summarize his findings in layman's terms, Dr. Campbell replied:

> There are subjective and objective findings. The subjective complaints of the patient, which were not always verifiable on the physical exam, were pain in the incision area of the right hip and the posterior buttocks. Pain that's in the buttocks is usually from the back. Hip pain is usually in the groin. And patients that have pain along the incision line, usually that's a result of either a form of bursitis and/or weakness of the hip abductor muscles. He did have some knee pain, but this was not of great significance to me, because he already had radiographic changes of degenerative arthritis in the left knee. As it says in my evaluation, the patient was not particularly a kind, considerate historian. I'll just leave my words to speak for themselves. Specifically on the physical exam, he did walk with a cane and had what's referred to as an antalgic gait, which is a gait that favors one leg. He complained subjectively of having popping and clicking in the hip on the range of motion, which was not reproducible on the physical exam. From my experience, the length, the size, the position, the function of the right hip was what I would expect for somebody who had had a total hip arthroplasty. The buttocks pain primarily was back in nature. It was not related to a herniated disc or slipped disc or anything that we would refer to found with straight leg raises or radiculopathy from the sciatic nerve. At the time that I saw him, there was no tenderness along the incision line, which was over what's referred to as the greater trochanteric or the trochanteric line. His sensibility was intact, and by and large there were not a significant number of findings associated with his physical exam. Since most of his hip [sic] was centered on the right side, I had previous x-rays and I had those repeated. And he had what is referred to as a total hip arthroplasty made by Almedico, which is the PCA. And the x-rays showed excellent position and alignment of the femoral component as well as the acetabular component without signs of loosening. And usually with signs of loosening what we look for are radiolucent lines which may exist between the prosthesis and the bone, abnormal positioning of the femoral component, or rotation or tilting of the acetabular component. And from my review of the previous records, these had not been noted by any of the other orthopedic surgeons to be any different from what I had seen. Dr. Bahri I think commented on those, and for the number of years that Dr. Fipp had seen him, there were no comments on that.

(CX 19 at 8-10).

Dr. Campbell was also asked what Claimant told him about when the popping or clicking in his hip started and again, Claimant had reported injuring himself in 1995 rehab. (*Id*. at 10). Dr. Campbell also testified: "But at the time that I saw him, he didn't have any of that, nor did he have the numbness and tingling of his legs on that right side which occur." (*Id*.). When asked, however, if this was a normal consequence of Claimant's surgery he said it was "probably not a normal consequence of it." (*Id*. at 11). He stated:

> It is a conceivable consequence of it and, in view of the patient's walking with a cane and having disuse atrophy to some degree of the leg, may result in that. ... But obviously this had not been occurring for the previous five or six years prior to this. ... On a physical evaluation, you don't ask them to walk a mile or climb up and down stairs, and you don't have them do a sustained amount of activity. So the fact that I cannot reproduce [the popping and clicking] may not have any great significance. I think, therefore, it's very, very difficult for me to make any tremendous significance to that.

(*Id*.). He also testified that popping and clicking is not normal for someone with a total hip replacement. He explains:

> Well, first of all, it's not normal. Second of all, it may have significance, and that brings up the secondary reason for doing the exam. In other words, if the patient has had a painless total hip arthroplasty and everything looks good, and then the guy comes in two or three years later and says he's got popping and clicking, the obvious thing is to, one, do a physical exam; two, do a radiographic exam. When you're left with the x-rays looking good, the physical exam being negative, then you start doing the million-dollar workup. In that case, that would be, you know, putting the guy on a treadmill and having a physical therapist watch him and document him. You could do selective injections in and around the hip joints, which is somewhat sort of like chasing your tail. So without any consistent, persistent localized popping and clicking, you're kind of at a loss as to what to do or make of that.

(*Id*. at 12-13). He testified that he was looking for loosening or change of position and found no sign of any problem. (*Id*. at 13-14). He explained:

> And, also, people that have loose prosthesis don't have pain in the back of the hip or on the side of the hip. The pain from a loose prosthesis either occurs in the anterior mid to distal third of the femur, if the femoral component is loose, or if it's in and around the cup area, then the pain is in the groin. And that's almost – you can etch that in stone.

(*Id*. at 14).

Dr. Campbell stated that he did not feel that Claimant needed any additional medical treatment for his hip condition when he evaluated him in 1997. (CX 19 at 15). He explained:

> Well, since this had been going on for a long period of time, he'd already seen Dr. Lemel, he'd already seen Dr. Bahri, who else I don't know, I just didn't – I didn't see that there was going to be a – you're always looking for fruit in the world. Well, I didn't see any fruit on this particular tree. And the patient had some supratentorial overlay associated with that, what sometimes we refer to as psychophysiologic musculoskeletal disorder. ... I didn't feel that he needed any additional treatment. ... It was my opinion at that time that the back pain, the hip

> pain, the antalgic gait and use of canes – that there was not going to be a good chance of changing that. The patient appeared to me not to be a good candidate for the only thing that might be appropriate for him, which would be an aggressive progressive resistance exercise program, musculoskeletal reconditioning. You know, and oftentimes in order to treat somebody, there has to be a meeting of the minds in which the doctor/ patient relationship is "I'm the doctor, you're the patient. This is what I want to do. If you don't want to do it, fine. See you later." And I didn't feel like he was going to be responsive to that sort of therapy.

(*Id*. at 15-16). He also stated that Claimant did not need additional surgery at this time. (*Id*. at 17). Dr. Campbell also stated that, as a rule he does not treat patients, such as Claimant, which are second opinions. He gives recommendations. (*Id*.).

Dr. Campbell was asked how long it would take the condition of Claimant, avascular necrosis, to develop, and he replied "years" it is "absolutely not" a condition that could occur over days. (CX 19 at 19). The condition was first noted in Claimant's November 10, 1987 x-rays. (*Id*.). He was then asked whether, Claimant's 1987 injury was just a temporary aggravation of that condition and replied:

> Possibly. Or, in view of the cyst and stuff like that, there could have been some microfracturing of the bone. In other words, people that have avascular necrosis, there is a continual remodeling process of the dead bone, and oftentimes you can have a microfracture that you may not see on x-ray which may exacerbate the pain. But, you know, so could any sort of injury. Because of the degenerative conditions which are inside the hip, it's not a normal hip. Therefore, any irritation or aggravation of it causes a more florid response to the environment of the hip, in other words, the white blood cells, the lining, et. cetera.

(*Id*. at 20). He agrees, however, that Claimant's avascular necrosis was unrelated to the accident. (*Id*. at 21). He agreed with Dr. Fipp's opinion that Claimant's excessive drinking of alcohol was a contributing factor to his avascular necrosis. (*Id*.).

Dr. Campbell stated that, despite Claimant's relating the popping and clicking to a specific incident:

> [I]t's like the avascular necrosis. It would have just been a matter of time before he had pain, if he hadn't already had it. The incident that he had was trivial, had nothing to do with the avascular necrosis, and it was just a matter of time before that condition rose its head and he was going to have pain and he would either have the choice of dealing with the pain, having a fusion of the hip or having a total hip arthroplasty. I mean, I just – I wish I could give you the answer that would be correct, but there is no correct answer.

(CX 19 at 33). He stated that Dr. Hardy's opinion was speculation, that he couldn't "imagine the scar tissue loosening six years, seven years after surgery." (*Id*. at 34). He explained that there were no clear clinical findings indicating surgery. (*Id*. at 35-38).

When discussing Claimant's underlying condition, avascular necrosis, He states:

> And we know that one of the primary reasons for [bone dying] is [heavy/ excessive drinking]. And you can just assure yourself that the collapse of the head occurred at some time well prior to his employment with you and the military, and it just takes a period of time before the irritation of the hip is such that it causes a painful response.

(*Id*. at 39-40). He added: "certainly an impact-type job could hasten the onset of symptoms. But it certainly isn't the etiology of the underlying condition." (*Id*. at 40-41).

Dr. Campbell was asked if he agreed with Dr. Fipp's opinion that Claimant's November 1987 injury was basically just a soft tissue type of injury and testified:

> I would tend to concur with that, other than the caveat that I made before, that sometimes, because this bone is a shell and slowly subsiding down, there's still some nerve fibers in there, and you could cause a microfracture of it. As a matter of fact, we see this commonly in patients that have hip fractures. You look at the x-rays and don't see anything there, but they have a stress fracture. You've heard of stress fractures. And you can x-ray people with a stress fracture and can't see a dad-gum thing.

(CX 19 at 41). He further stated that Claimant's hip pain, prior to his surgery could have been any number of things. (*Id*. at 42). He further elaborated:

> If you saw Dr. Fipp and his physical exam of [Claimant's] hip, he had almost no motion in it. Okay? I can take my hip and I can move it around like this and up and down. This guy couldn't rotate it more than about that far and that far (demonstrating). Okay? And if you read that part of his physical exam, this guy had a severely restricted range of motion of his hip due to scarring, pain. And you don't get that overnight. Okay? You just don't – you just don't sit there one day and you can move your leg up and down and one day you can't do it but like this (demonstrating). So the ongoing aspects of his hip, that takes a period of time for you to develop the sort of contractures that he had in his hip.

(*Id*. at 43). He also agreed that when he evaluated and examined Claimant in August of 1997 he did not see any early loosening of the femoral component. (*Id*. at 44). Dr. Campbell reiterated that the first time Claimant was seen by Dr. Fipp, he had just a few inches of movement in either direction, which was indicative of the fact that the scarring and disease process was ongoing. (*Id*. at 45). He testified that Claimant could not, at that time, have crossed his right leg with the right hip condition, with the range of motion described by Dr. Fipp in his report. (*Id*.).

Veteran's Administration Records

In a report dated July 2, 1998, Claimant was seen by Dr. Thomas E. Kirk. Dr. Kirk wrote "Clinical history of right hip pain for approximately six months. ... An AP film of the pelvis with

both hips in the neutral position, as well as an AP film to include all the metallic hardware, and a frog leg lateral of the right hip were obtained. ... There is no evidence of loosening or infection. In addition there is no radiographic evidence of cement. The left hip joint and remainder of the bony pelvis as well as the sacroiliac joints also appear intact." (*Id*. at 16).

Claimant again saw Dr. Kirk on June 7, 1999. Dr. Kirk again noted that Claimant has a clinical history of low back pain. After x-rays it was noted that there was good alignment "with well maintained vertebral heights and intervertebral disk spaces. There is no evidence of a fracture, dislocation, or significant arthritic changes, and the sacroiliac joints appear intact. Again noted is evidence of a previous total right hip arthroplasty, which according to the patient was performed in 1989." The impression was negative LS spine with evidence of a previous total hip replacement. (EX 6 at 30).

In a progress note dated January 5, 2000, Claimant reported feeling depressed and anxious. The notes stated:

> 53 year old wm with hry of recurrent episodes of anxiety and depression since '94 after he was fired from his job at Lockeed [sic]. Per his report he was unfairly charged with stealing. After this incident took place he felt angry, depressed and betrayed; these symptoms became progressively worse to the point of requiring inpatient psychiatric care. I have no documentation regarding such hospitalization, but per pt's report he was diagnosed with BAD and has been undergoing treatment with wellbutrin 150 mgrs PO BID and Depakote 500 MGRS PO BID with good response to treatment. At the time of this evaluation he does not have any specific complaints except pain in R lower ext.

(EX 6-21, 22). At this time, Claimant's diagnosis was noted as follows:

> Axis I Depressive disorder NOS
> PTSD by HRY
> ETOH Dependence in remission
> r/o OCD
> Axis II: Deferred
> Axis III: See PMH
> Axis IV: Chronic pain, financial problems
> Axis V: Current GAF 70 to 80.

The doctor also writes: "[Claimant] has a hry of recurrent episodes of anxiety and depression since 94; the magnitude of these symptoms worsen after he became unemployed. Hry is also significant for avoidant behavior, startle response and recurrent nightmares without evident feelings of guilt. Plan: no changes in regimen." (EX 6-25).

Dr. Steven J. Novack

In this outpatient consultation for Claimant's multiple pain complaints, dated July 9, 1998 by Dr. Steven J. Novack, he states that Claimant has been referred by his case manager. He

writes that Claimant said he was in "good health until he had an industrial accident in the late 1980's. This resulted in a right total hip replacement he believes in 1989. He seemed to be doing well in regard to his right hip until he says the insurance company made him go to a work hardening program. After that he began to have right hip pain and lower back pain." (EX 19 at 1). He also had carpal tunnel release. (*Id*.). He noted that Claimant stated that he has a constant but variable aching sensation in his lower back without radiation which is increased with activities as well as prolonged sitting. (*Id*.). Claimant also stated that he has discomfort in the right hip that is constant but variable aching pain increased with walking, standing, or sitting. (EX 19-2). He then performed a physical examination on Claimant. (EX 19-2,3). He noted that Claimant:

> ambulated with a straight cane with a limping on the right lower extremity secondary to hip pain, but his gait was safe and functional. His neurological exam of the cervical and lumbar regions did not indicate a cervical or lumbar radiculopathy. Obviously this is a difficult case with chronic pain being involved in several different areas including the wrists and hands bilaterally, right hip, lower back, and more recent right shoulder or right upper back discomfort.

(EX 19-3).

On July 28, 1998, Dr. Novack responded to questions asked by an attorney:

> In regard to [Claimant], I do feel that he is at MMI for conservative treatment concerning his various pain complaints. In regard to impairment ratings, I refer to a note from Dr. Lemel dated 1/7/97 that recommends a 3% permanent impairment rating per side, carpal tunnel releases, for a total of 6% total body PPD rating. I don't recommend any further treatment at this time. His condition is stable. His diagnosis has been stated including bilateral carpal tunnel release and his overall prognosis taking into account the longevity of his multiple complaints is fair.

(EX 19-4).

On July 30, 1998, Dr. Novack commented on Claimant's July 9, 1998 driving assessment. (EX 19-5). He writes:

> The overall recommendation was that Mr. Muse not return to driving due to anxiety issues and their negative impact on his driving performance. From a physical standpoint he met all the criteria but the therapist noted the anxiety was the major drawback. This somewhat coincides with his physical examination that showed he had functional ability with a lot of subjective type complaints regarding his memory and anxiety issues. With these type of findings it may be appropriate to get a neuropsychological evaluation with Dr. McAleer to see if there is any objective data regarding his multiple subjective type complaints.

(*Id*.).

Dr. Philip Hardy

In a letter dated August 12, 1998 to Claim Representative McMillan, Dr. Philip R. Hardy[13] discussed his independent medical evaluation of Claimant. (EX 26). He wrote:

> According to the medical records which accompany [Claimant] today, he developed avascular necrosis of the right hip and underwent a right total hip arthroplasty performed by Dr. Fipp. The etiology of the AVN at that point, was related to an injury which occurred during the course of his employment when he fell on November 6, 1987. It is also noted that Mr. Muse was an alcoholic and this is also a known cause for AVN.
>
> He is seen today primarily with regard to a popping and snapping of the right hip. He indicates that this occurred some two years ago while in a rehabilitation work hardening program and a program which involved significant exercise of the right hip and lower extremity in general. Subsequent to that, the popping and snapping appears to have evolved and he indicates that this is painful to him and limits his ability to perform activities of daily living. He also indicates that he followed Dr. Fipp's orders and has in fact, never crossed his leg since surgery and has restricted his ROM to an extent which is unusual but he is doing so in an attempt to limit the rate of wear and tear of the hip replacement.

(EX 26 at 1). He noted that there were no x-rays with Claimant, but stated that according to Dr. Fipp's interpretation of the x-rays there was some bony ingrowth about the components. (*Id*. at 2).

In describing his physical examination of Claimant, Dr. Hardy noted that Claimant was "unable to recreate the popping with which he is concerned." (EX 26 at 2). He noted:

> [Claimant] has pain which radiates from the groin to the knee, about the medial aspect of the thigh and it appears that this in fact, may be due to irritation of the obturator nerve and this may indeed explain the discomfort about his knee and would in fact, be reasonable cause in view of the hip replacement.

(*Id*.). In discussing Claimant's x-rays he wrote:

> X-rays of the right hip obtained today, demonstrate a radiodense line about the femoral component, even though there is some densification about the calcar, it appears that indeed, the femoral component has developed some loosening and indeed may in fact, have bony fibrous ingrowth. The acetabular component appears to be to the inner border of the acetabulum, unfortunately without prior x-rays, it is not possible to know if this in fact is migration or whether in fact the component was placed there initially. Additionally, it is not possible to determine

[13] Dr. Hardy's curriculum vitae is in evidence at CX 23.

> whether in fact, there is eccentric wear of the component, although certainly in a replacement of this age, it is highly likely. It is also likely that the snapping and popping is due to the extent of the eccentric wear. The alternative explanation could be the fact that because he was grossly restricted in motion following surgery as an voluntary attempt to reduce the rate of wear-and-tear and the exercise program in fact, stretched out the scar tissue and musculotendinous units about the hip and this permitted him an increased motion to the extent that he is now able to snap or pop the scar tissue or a muscle tendon unit over the area of the hip replacement.

(EX 26 at 3). His assessment is that "of a painful popping of the right hip due to either wear or possible stretching of scar or musculotendinous units across the hip replacement area." (*Id.*). His recommendation states that Claimant's x-ray's

> do not demonstrate evidence of incipient failure of the component, even though there is apparent early loosening of the femoral component. There are no cystic changes about the bone and no evidence of gross subsidence. Therefore I would recommend that he put up with the local discomfort about the hip for as long as possible and in the event that he did in fact reach that stage where he requires a revision in someone of his age group, he would best be served by being referred to Shands teaching hospital....

(*Id.* at 3-4). He also noted that Claimant was on total disability due to his wrist problems. (*Id.* at 4).

On July 29, 1999, Claimant again saw Dr. Hardy. The physical exam reveals "quite painful in the lower back with right paraspinal muscle spasms. He clearly has localized sensitivity in the low back." (CX 21 at 10). Dr. Hardy recommended avoiding a revision procedure as long as possible. (*Id.*). He also completed a certificate of medical necessity for a power operated vehicle. (*Id.*). *See also* (CX 21 at 3)(certificate).

On January 20, 2000, Claimant returned to Dr. Hardy. At that time he had continued complaints of pain in his hip and back. (CX 21 at 10). Dr. Hardy noted:

> X-rays of the right hip obtained today, demonstrate fortunately even though there is obvious loosening of both the femoral as well as the acetabular components, there does not appear at this point, to be significant or progressive bone loss.

(CX 21 at 11). At that point Dr. Hardy's recommendation was a referral to Dr. Hurayt for continued pain management and depression. He also noted that Claimant was permanently disabled. (*Id.*). On June 19, 2000, Claimant returned to Dr. Hardy with an onset of right hip pain. He reported that, since obtaining the cart, his symptoms had been improved. After climbing stairs, however, he developed an acute onset of hip pain. (*Id.* at 12). The x-rays taken on this date "demonstrate if anything that he appears to have less of a radiolucency around his hip than he has had in the past." (*Id.*). Dr. Hardy prescribed medicine for Claimant. (*Id.*).

On September 6, 2001, Dr. Hardy was deposed. (CX 22). Dr. Hardy was asked about Dr. Fipp's opinion that Claimant's fall in 1987 was a temporary aggravation of his underlying condition. He replied:

> Well, it seems as though from my understanding of what Dr. Phipps' [sic] records then subsequently showed is that the patient's symptoms never resolved following that fall. As a result of which, one would therefore use the benefit of retrospect to say that the aggravation turned out to be a permanent one rather than a temporary one.

(CX 22 at 7-8). He agreed, however, that drinking and steroids were known to have a causal relationship with avascular necrosis. (*Id*. at 8). Dr. Hardy did not have the notes of Dr. O'Connell, Dr. Bahri or Dr. Campbell. (*Id*. at 10).

Dr. Hardy was asked to explain what his examination of Claimant revealed and testified:

> The medical records, I indicated those. The patient was unable to recreate the popping of which he was concerned at the time I saw him. He did identify that he had pain radiating from his groin toward his knee about the medial aspect of his thigh. We proceeded with x-rays on that date, and they demonstrated to me that he had some failure of bony ingrowth about the component – about the hip and that also there was some evidence of–there was a question of some evidence of where – of the polyethylene liner of the component primarily interested at this point in seeing how this replacement has done since at this point it's already nine years old. And where as a hip replacement ages, it's quite typical. It did appear as though there may, in fact, have been some wear of the component. The other finding was he had an unusual degree of restricted motion and was unable to basically cross his legs over each other which is something that would normally have been expected. ... He seemed to be physically unable to. He was – gave me the impression then, as my notes reflect, that Dr. Phipp [sic] initially told him to avoid crossing his legs, which is typical information for the first six weeks, in order to minimize the risk of dislocation of the hip. Generally, after that, patients just resume their activities and eventually regain that motion.

(CX 22 at 12). He explained that since Claimant never attempted to cross his legs after that, that may explain why he never regained that motion. (*Id*.). Dr. Hardy continued:

> And that was really the summation of the clinical evaluation as far as the hip replacement was concerned. I felt the popping may be due to the extent to which there was some wear in the components. I also identified the fact that the patient had failure of bony ingrowth and I thought, therefore, the potential for the development of gradual loosening of the attachment of the components to the patient's bone.

(*Id*.).

When asked about the effect of Claimant's work-hardening program on his hip, Dr. Hardy replied:

> I would seriously doubt that almost any type of physical therapy regimen is going to make any substantial difference to the actual components themselves. I would suspect that if, in fact, the patient was quite tight around the hip joint and was then put through a program with increased levels of activity beyond that which was typical for him, it's possible that he could develop discomfort around the hip as a result of the muscles and/or the tendons being subjected to an increased amount of activity. But I would not seriously believe that that type of program would produce any measurable degree of wear of the components that wasn't already there. It is conceivable that if presuming the patient already has a failure of bony ingrowth of the components and therefore has what is it called a fibrous ingrowth which tends not to be pain free, that increased level of physical activity could increase discomfort associated with that fibrous ingrowth of the components. And that would be about as much as I would realistically expect a work-hardening type program is likely to cause to a hip replacement that's of that age. ... I would still not envision a work-hardening program to produce a permanent injury to the actual components themselves. I wouldn't expect them to produce loosening of the components that wasn't already evidenced. I wouldn't expect him to break any pieces off. I could envision, if the patient had significant scarring or stiffness about the hip already present, that then if you loosened it up to any degree – now we're not talking about the actual components but the actual muscles and tendons around the area, that he could, as a result of that, generate a snapping that was uncomfortable to the patient. But I would not really expect that that would alter the anticipated useful life of the hip joint.

(CX 22 at 13-15). He finally testified, concerning the 1995 incident, that:

> It's of relatively minor significance. I pretty much reached the opinion that there was no permanent alteration of hip as a result of the events of '95 anyhow. And the fact that his hip has lasted as well as it has, just simply reinforces that opinion.

(*Id*. at 34).

Dr. Hardy testified that you could perhaps increase sensitivity in an area of fibrous growth but he seriously doubted that it could be pulled loose measurably. (CX 22 at 15). He also speculated that there was a possibility that if Claimant's components had significant wear, increased activity could have meant that it loosened up enough to actually move the ball in the socket enough to get a snapping sensation, or he could have loosened up scar around the muscles and the tendons enough to produce the snapping that was not previously evidenced or that discomfort from the fibrous ingrowth area could be increased as a result of stress. But he does not really believe that work hardening exercises described would result in loosening the components that wasn't already there. (*Id*. at 16).

Dr. Hardy also reviewed the x-rays from Dr. Campbell taken in 1997. (CX 22 at 18). He

testified that the hip was in the correct position, and that there was fibrous ingrowth. (*Id*. at 19). A question was unanswered, which was whether the socket part had migrated. (*Id*.). He testified:

> The reason I raise that question is, on my x-rays, the socket was right up against the inner wall of the pelvis. And sometimes after the replacement the component is already placed right there – which is fine as long as it doesn't move beyond that point. Unfortunately this x-ray is basically within a year of the x-rays that I took. So it still does not really answer the question as to whether, in fact, it was in that position following the surgery or whether it had migrated to that position since the surgery. But you can still see on these x-rays now evidence of fibrous ingrowth–failure of bony ingrowth in other words.

(*Id*.).

When asked if this x-ray showed loosening, he stated that it showed the same thing that he saw:

> Fibrous ingrowth is associated with some degree of loosening of the component. In other words, there's no true bony solid ingrowth into the metal component. Fibrous tissue is like scar tissue. Therefore, it allows some motion between the metal component and the bone which is not ideal and is therefore some degree of concern because it often produces some degree of discomfort for the patient. On the other hand, there are patients that have fibrous ingrowth which is stable. In other words, even though it's not ideal, and it produces some kind of aching discomfort, some kind of discomfort with activity, the components, in fact, do not get progressively more and more loose, they just stay that way for prolonged periods. That is quite a common situation. And it appears to be what's going on with this patient.

(CX 22 at 19-20). He also testified that the x-rays he took in June of 2000 actually appeared to indicate the condition had improved somewhat. Although he stated that it was quite difficult to make those two x-rays comparable because the patient is never in precisely the same position and the actual penetration of the x-rays and the performance of the developing liquids are always different. (*Id*. at 20-21). He clarified and said, that Claimant's hip was not worse, and if it is any different, then it's better. (*Id*. at 20-21). He did prescribe pain medication. (*Id*. at 21). Based upon his own x-rays, however, he did not see any sign of progressive loosening of the components. (*Id*. at 23). He testified that wearing of the polyethylene lining is really difficult to see. It would have to be seen on an MRI, if at all. He saw no indication that there was any change in the position of the hip, that it looked stable. (*Id*.).

Dr. Hardy confirmed that the back problems Claimant related to him or that he has observed are not, in his opinion related to the original injury and are caused by some other event or condition. (CX 22 at 25). Once Dr. Hardy realized that Claimant had been complaining of back pain as early as 1997, however, he testified:

> I mean, certainly there are patients in whom having a persistent limp does put additional strain on the back. The particular type of presentation the patient had in April of '99, to me, was not of that type in its relatively acute onset and its location. So I don't know that we were necessarily dealing with the same type of back problem. That was why I reached the opinion I did on that date in April 29 of 1999.

(*Id*. at 32-33). He agreed, however, that if it were true that Claimant had been limping and walking with a cane essentially since his surgery and if he assumed that Claimant had had episodes of back pain for a number of years prior to when he saw him then the back pain could have been related to his abnormal gait and limping. (*Id*. at 33).

Dr. Hardy was also asked what he typically would recommend as the normal restrictions following a hip replacement and replied:

> We typically recommend that they don't lift any heavy objects, suggesting no more than 50 pounds or so, particularly on a frequent or repeated basis; try and avoid impact loading such as jogging or activities of that kind, and try and reduce or let's say maintain their weight at as low a level as they reasonably can all in an attempt to try and decrease of the rate of wear of the component. And that is really about it.

(CX 22 at 26). He stated that climbing stairs was limited only to the extent that it adds wear and tear. (*Id*.). He further testified that Claimant's hip is verging on the area of being somewhat better than average given his treatment of it and it's condition. (*Id*. at 27). He did not restrict Claimant from going back to work or put him on permanent disability. (*Id*. at 27-28).

Dr. Hardy again reiterated that Claimant's history, as related to him, indicated a permanent rather than a temporary aggravation of his hip condition. (CX 22 at 28-29). There was no progressive loosening. (*Id*. at 30). Dr. Hardy did not recommend surgery the time he first saw Claimant in 1998 nor did he recommend it at the time of the deposition. (*Id*.). He did opine, however, that Claimant will eventually need another hip replacement, just due to wear and tear. (*Id*. at 25-26).

Dr. Hardy testified that he is not able to state that there was any objective evidence of a new injury as a result of Claimant's exercise program and

> I have not heard that popping that he has described. And to the best of my knowledge, there is no x-ray change that's [sic] has been attributed to that. Therefore, I do not identify any objective evidence.

(CX 22 at 31). He further testified that, putting aside Claimant's hands, psychological condition and back, dealing just with the hip, that he believed Claimant would be able to work under his general restrictions. (*Id*.).

Dr. Hardy agreed that, the treating and operating physicians would probably be in a better

position to render an opinion on the nature of Claimant's injury in 1987, presuming he had the information as to the nature of the injury. (CX 22 at 35). He stated:

> The basis for my opinion is merely as the observer that ostensibly the patient had no symptoms before the injury, and ostensibly had them afterwards and he never got better. On that definition alone, it would have to be permanent, just on that basis.

(*Id*.).

Dr. Hardy was also asked again about his opinion regarding Claimant's 1995 incident. He agreed that the Claimant stated that he had no pain until then and since then he has had pain and he testified:

> To the extent that the patient has increased complaints of discomfort [that is some indication that there has been a change in condition]. But that still does not indicate that I have seen an objective change in the hip replacement or that I think it would necessarily have to be revised any sooner.

(CX 22 at 37). He agreed that the x-rays only showed the harder substances and not the soft tissue surrounding the hip. (*Id*. at 38). He reiterated that in the three years he has seen Claimant there have been no objectively identifiable change in his hip. (*Id*. at 40).

Dr. Mark Friedman, Psychiatrist.

On October 13, 1989, Dr. Mark Friedman[14] reported that Claimant was seen on August 30, 1989 and October 4, 1989. He had been treating him "under the diagnosis of Dysthmia." (CX 35 at 1). Anxiety was also noted. (*Id*.). Claimant was experiencing stress at work and home. Prozac was prescribed. He was referred to an internist for hives. (*Id*.).

On April 4, 1990, Claimant returned to Dr. Friedman. Claimant reported Lockheed was cutting employees. Dr. Friedman noted that Claimant has been seeing "Roberta" for psycho-therapy. He also noted that Claimant's mood was good and he was sleeping well. The assessment was to continue current treatment. (CX 35 at 5).

On September 18, 1995, Claimant was referred by Mark S. Lemel to Dr. Friedman. (EX 30 at 54-56). On history of present illness, completed by Claimant, he dated his current depression as Christmas of 1994, past history is his 1989 depression, treated with prozac and quit when he went back to work. It is noted under Assessment, axis IV: "Current social stressors moderate in that obviously Roland cannot work." The recommendations are to resume prozac, group and individual therapy. (*Id*.); (CX 36 at 1-3). On December 22, 1995, Claimant returned to Dr. Friedman. He reported sleeping better, and good mood. Increased nightmares about Vietnam are noted, however. Overall Claimant seemed to "be doing a lot better," and an

[14] Dr. Friedman's curriculum vitae is in evidence at CX 38.

excellent response to medicine was noted. (CX 36 at 4).

On October 20, 1995, Claimant first was referred to the Adjustment to Disability group within Dr. Friedman's practice. The therapist, Janet Gray wrote:

> Apparently he had one job related accident which was followed with a hip replacement surgery. He returned to work until 1994, when he had the second accident. He has not been able to work again since. He reports that he became severely depressed in December of 1994 when he realized he could not provide Christmas gifts for his children. He was treated in our office back in 1989 after the first accident. Dr. Friedman administered Prozac and he discontinued this when he was able to return to work. He is a Vietnam veteran and frequently has flashbacks about this. He states that have become more frequent and more intense since his job related accidents... He becomes angered several times in session, talking about the chain of events since his last job related accident.

(EX 30 at 53). In a note dated December 15, 1995, Janet Gray reviewed an individual therapy with Claimant. The session was scheduled because of his extreme anger and anxiety. They focused on his Vietnam experience. Ms. Gray discussed how the accident could have been a trigger for Claimant, then wrote:

> The patient appeared very, very relieved. He can now make a connection between the major depression and the severe recurrence of PTSD symptoms that began in 1989 when he had his first job related accident. Since he has been off the job they have gotten more severe and now that he is at home full-time with little to occupy himself, the symptoms are overwhelming.

(*Id*. at 49-50).

On February 9, 1996, Janet Gray wrote a "adjustment to disability group" memo regarding Claimant. In a group therapy incident he escalated and reinforced talk of anger and violence, then cursed at the therapist. (EX 30 at 46). She wrote:

> I suspect Roland is in crisis with Post Traumatic Stress Disorder and truthful memories and flashbacks from not only the Vietnam era but from trauma from his job related accidents.

(*Id*.). In a progress note dated February 13, 1996, Janet Gray discussed Claimant's history, from childhood on, and addressed his decision to admit himself to a hospital, saying "he needs psychiatric hospitalization. Despite all of our efforts here with medication management, group therapy, and individual therapy, he is not stabilizing yet." She concluded by writing:

> Will continue to allow this patient to be seen in group and individual therapy until we can get him off to a hospital. He has no suicidal or homicidal ideation at present which is good. We will go ahead and write a letter to support his admission. I do hope that his Worker's Compensation Carrier will provide, at least

> partially, for his care as this most recent trauma that ' tipped the scales' to destabilize him was definitely the Worker's Compensation injury.[15]

(*Id*. at 44-45).

On February 20, 1996, Dr. Friedman wrote a letter to the Veteran's Administration. Dr. Friedman stated that Claimant's diagnosis included, among other things: major depression, recurrent, moderate post traumatic stress disorder, chronic R/O obsessive Compulsive disorder; R/O personality disorder; carpal tunnel syndrome (both arms) secondary to repetitive movement injury, and history of right hip replacement. (CX 37 at 1). He explains that he provides medication management, and Claimant receives individual and group psychotherapy through his practice. (*Id*.). He reported that Claimant:

> has not been very stable during his treatment at our facility. He admits that he may have some problems with self-esteem and self-image that go back to childhood. Secondarily, he has tremendous trauma from the Vietnam experience. Thirdly, the effects of the job related accident have exacerbated both previous conditions.

(*Id*.).

Dr. Friedman explained that he and the staff at Sunbelt Behavioral Health Services, P.C. treated Claimant primarily for the treatment of the depression that related specifically to the job accident, although "[w]e understand that all of his problems are piled together in some way and that they have all been exacerbated by the former." (CX 37 at 1). He stated, however, that more specific treatment is needed for Claimant's Vietnam trauma. (*Id*.). Dr. Friedman described Claimant's behavior in group therapy, on two different occasions rising to the level of threatening and violent. (*Id*.). He stated that what they are offering, although fairly comprehensive, is not enough. He felt Claimant needed an intense outpatient program with a trained and qualified group leader to deal with his flashbacks and anger, or better yet, an inpatient program, as "this patient appears to be rather dissociative." (*Id*. at 2). Finally he wrote:

> This is a bright and well-motivated individual. He is not attention seeking, nor looking for secondary gain or treatment. The fact is not that he does not want to settle in and stabilize, it is clearly that he has too many symptoms of trauma flooding him all at one time.

(*Id*.).

In a psychiatric evaluation prior to Claimant's admission into an inpatient program, performed by Dr. Friedmen and dated February 24, 1996, Claimant's chief complaint was: "If anybody comes up here to check on me, they better watch out." (EX 31 at 4). Based upon this, Dr. Freidman's assessment was:

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[15]Although Ms. Gray does not specify which work-related accident she is referring to, due to her reference to "this most recent trauma" and the timing, it is assumed she is referring to Claimant's onset of carpal tunnel syndrome.

> Axis I: History of depression, recurrent, severe. Post traumatic stress disorder, chronic in nature, acute exacerbation. Rule out obsessive compulsive disorder, predominantly with obsessive thinking.
> Axis II: Personality disorder, NOS.
> Axis III: Carpal tunnel syndrome, secondary to repetitive movement injury. Status post right hip replacement.
> Axis IV: Psychosocial stressors, severe, in that obviously he needs to be in an institutional setting for his safety and the safety of others.
> Axis V: Current GAF 30; over past year 70.

(*Id*. at 6). His recommendation:

> The patient is admitted to the New Visions Program at CBTS Hospital. He is here for further evaluation, medication management, individual, group, and family psychotherapy.

(*Id*.). The estimated length of stay was two weeks. (*Id*.).

Claimant was admitted to the New Visions Center for Health and Wellness on February 24, 1996 and discharged on March 6, 1996. (CX 34 at 2). The Claimant presented with:

> 1.) Anger, Intense Feelings of
> 2.) Depression and Sadness, Feelings of
> 3.) Trauma: Impairment/ Distress
> 4.) Family of Origin Issues.

(*Id*.). His stressors at this time included depression, post-traumatic stress syndrome, altercation with insurance agent for worker's compensation claim, and intense physical pain due to a total hip replacement operation and the carpal tunnel surgery. (*Id*.). It was noted that Claimant gained insight into the following:

> Family structure, trust issues, health relationship behaviors; addictive life styles and the 12 step process; understanding the treatment process; medication management; coping styles/ meditation/ imagery/ diet/ exercise/ journaling; genograms and family cycles; boundary setting, recovery issues and discharge planning.

(*Id*. at 3). Recommendations included returning home, following up with outpatient treatment and attending support groups. (*Id*.). A later letter states that Claimant attended weekly group meetings in Waycross, Georgia from mid-1996 until February 1997. (*Id*. at 4).

Claimant was discharged from Charter by the Sea (New Visions) Hospital on March 6, 1996. (EX 31 at 7). At that time, Claimant's present illness, mental status on admission, admitting diagnosis, history and physical, consultations, laboratory data and hospital course were reviewed. (*Id*. at 7-8). The hospital course stated that Claimant was admitted on a voluntary basis and integrated into group, individual, RT, OT and family therapy. (*Id*. at 8). He remained in one on one line of sight to insure his safety and the safety of others due to " his recent behavior

and continued poor impulse control." (*Id*.). As Claimant neared discharge, he continued to maintain medical stability, denying suicidal or homicidal ideation. (*Id*. at 9). He was "interacting in a stable fashion." (*Id*.). His discharge diagnosis was listed as:

> Axis I: 1. Major depression, recurrent, severe.
> 2. Post traumatic stress disorder, chronic.
> Axis II: Personality disorder.
> Axis III: carpal tunnel syndrom. Status post right hip replacement.
> Axis IV: severe.
> Axis V: Admission GAF 30. Highest past year 70. Discharge GAF 70.

(*Id*.). His condition at discharge was noted as:

> The patient appeared to have returned to a premorbid level of functioning. He was not appearing to be an imminent danger to self and/or to others. He was discharged on Trazodone 50 mg po at hs. Wellbutrin 75 mg one po bid. Depakote 500 mg one po tid. Tylenol one to two as needed for hip pain every six hours.

(*Id*. at 9). On March 20, 1996 Claimant returned to Dr. Friedman after being discharged from Charter By-the-Sea Hospital, New Visions program. He noted that Claimant "improved significantly with hospitalization," although Claimant was still having trouble sleeping. (CX 36 at 8).

On April 8, 1996, Claimant returned to Dr. Friedman who noted that Claimant's increased medication was helping him sleep better, but that he still reported pain in left hand. Dr. Friedman wrote:

> [Claimant reports] Workman's Compensation Carrier is refusing to allow him to see a physician about his hip claiming that it was a preexisting condition and not their responsibility. Meanwhile he is stumbling and falling more. He cannot use the crutches because the crutches are causing him intense lower back pain. 'I'm just in a real low period now.' Misses being able to drive.

(CX 36 at 9). He also noted that, by Claimant's report, he reinjured his hip while going through a work hardening program. (*Id*.).

In a progress note dated July 3, 1996, Dr. Friedman noted that Claimant misunderstood him about not being able to drive, but that his mood was good, he was sleeping well and attending all of his group sessions. He cleared him to drive, fish and boat, and noted that Claimant exhibited good anger control with a stable mood. (EX 30 at 40). On September 4, 1996, Dr. Friedman noted that Claimant appeared to be "at a base line level of functioning. He is now maintenance phase. Good control of his anger." (CX 36 at 14).

In a note dated September 16, 1996, Janet Gray wrote that she "prefer[ed] that [Claimant] confine his therapy here to that which relates to the job accident." (EX 30 at 36). On October 30, 1996, Claimant returned to Dr. Friedman, noting that he felt pressured to take a leadership

role in his disability group and does not want to. Dr. Friedman noted that Claimant's medications will continue, as they seem to be well-adjusted. Also, that Claimant needed to "work to get through his guilt and practice his assertiveness skills in group. ...He also needs to discuss his fear of some of the group members threatening suicide given his history of having other people that he cared for die under his command. [Claimant's] chronic pain seem to be exacerbated by stress, weather condition and other circumstances. ... " (CX 36 at 16).

In a progress note by Dr. Friedman dated January 8, 1997, it is noted that Claimant wants to go back to group therapy plus individual therapy with Janet Gray as he does not get along with his new therapist Nancy Hughes. He noted that Claimant "realizes that his anger is getting out of control and he does not know what to do about it." (EX 30 at 35). He is reconsidering his therapy and continuing all of his current medications. (CX 36 at 18).

In a progress note dated February 19, 1997, Janet Gray writes of her problems with Claimant, and reviews her therapy history with him. She stated the pervasive themes from Claimant include: 1) nobody listens to me; 2) nobody knows or understands me and where I am coming from; 3) it is unfair, people do me injustice. She also talks about his "trust" issues. She concluded: "I do know that Roland needs medication management and psychotherapy to help him adjust to the depression that is subsequent to his last job injury and the fact that he is no longer able to work." (EX 30 at 32-34).

Claimant returned to Dr. Friedman on June 5, 1997. (CX 36 at 21). He noted that Claimant reported that his chronic pain had increased somewhat, which he attributed to the change in weather. (*Id*.). On July 3, 1997, Claimant returned to Dr. Friedman. (CX 36 at 22). At that time, Claimant's wife had lost her job, his son had a broken leg, and Claimant was impatient with his workers' compensation case and has hives. Dr. Friedman noted:

> 1. Roland's financial status has seriously worsened. He is quite angry and frustrated about this. About the only thing I could do to help him at this time is to provide what little supportive therapy we can to help him.
> 2. He continues to diet with good result.
> 3. His mood otherwise seems to be fairly stabile [sic]. Will continue all his medications to treat this.
> 4. His chronic pain seems to have worsened particularly having difficulty with his right knee. This may be related to some type of structural readjustment that he is making to avoid pain. ...

(*Id*).

On June 9, 1997, Claimant's new therapist, Dr. William R. Johnson wrote that Claimant seemed much calmer, he stated that Claimant told him that Dr. Friedman had encouraged him "to go ahead and enter the VA inpatient program for PTSD. We talked about some of the pros and cons of this and about some of his previous treatment, particularly with Ann Madden." (EX 30 at 29). On July 11, 1997, Dr. Friedman wrote a letter addressing the fact that Claimant had not received some of his medications due to lack of payments. He explained that all of the medicines were necessary to avoid hospitalization, homicidal ideations and to lessen pain and symptoms (weight loss, sleep). (*Id*. at 26-7).

In a progress note dated August 26, 1997, Dr. Friedman noted that Claimant reported the last three weeks he had been having severe leg cramps and that the week before he had fallen in the shower and had increased back pain. (EX 30 at 24).

In a patient note from Sunbelt Behavioral Health Services (Sunbelt), Dr. Friedman's practice group, dated January 6, 1998, it is noted that Claimant's right leg has been giving out on him more and he has been falling. (EX 30 at 18). On January 20, 1998, Claimant returned to Dr. Friedman complaining of insurance adjusters trying to break into his house. Dr. Friedman noted "it is not clear what is going on in his home. They live out in the woods and his wife is confirming his suspicions." (CX 36 at 23). In a patient note from Sunbelt dated February 10, 1998, it is written: HX of hives ...–"once when he found out he needed his hip replaced-1989; not again until Oct. 1994; once + a week since." (EX 30 at 16).

On March 17, 1998, in a patient note by Sunbelt, it is noted "no purposeful work or interest in [Claimant's] life today. Nothing to get up in the mornings for." (EX 30 at 14). In a handwritten note dated March 24, 1998, it was noted that Claimant expressed anger regarding various issues including health, VA and social security. (EX 6 at 44). In a handwritten note dated March 31, 1998, it is noted that the doctor met with Claimant and his wife to discuss his condition. Claimant reported increased poor health and irritability and lack of sleep. He was unable to drive and dependant upon wife, who was unemployed at this time. (*Id*. at 45).

In a letter from Dr. Freidman dated May 14, 1998, he wrote:

> [Claimant] is a patient under my care for Major Depression and Post Traumatic Stress Disorder. He experiences significant concentration and short-term memory impairments as well as alteration in his perceptions of his immediate environment. I have instructed [Claimant] to discontinue driving indefinitely as the aforementioned symptoms places himself and other in danger on the road.

(EX 30 at 12). On August 4, 1998, Claimant returned to Dr. Friedman. Transportation to treatment was no longer being paid for, so he had missed appointments and group therapy. Viagra was working but the insurance would not pay for it. Dr. Friedman noted: "I do not understand why his workman's compensation carrier will not reimbuse [sic] him for this as I do believe this erectile dysfunction is either a consequence of his workman's compensation injury or a side effect of the medication used to treat the conditions generated by his injury." (CX 36 at 24).

Dr. Andrew Hurayt

On March 20, 2000, Dr. Andrew Hurayt[16] performed a psychiatric evaluation on Claimant. (CX 39). Claimant was referred to him by Dr. Friedman, who became ill and disabled. He reviewed Claimant's history of injury and stated that Claimant used a scooter to get around his house, continued to have chronic pain when walking down steps, and cannot sit in one position

[16] Dr. Hurayt's curriculum vitae is in the record at CX 41.

for more than 10 minutes without getting severe hip pain. (CX 39 at 1). His current diagnoses were listed as: Major Depressive Disorder, Secondary to hip injury and disability, chronic pain syndrome due to hip injury; level of stress is severe due to physical disability, loss of job, and financial stress. (*Id*. at 1-2). He further stated:

> It should be noted that there is no history of psychiatric treatment or psychiatric illness prior to his work related injury in 1987. I believe that his psychiatric condition is entirely due to the stress and disability of the 1987 work-related injury and its physical, emotional and financial ramifications.

(CX 39 at 2). He recommended ongoing psychiatric evaluation and medication management and supportive therapy every two months. (*Id*.). On June 14, 2000, Dr. Hurayt wrote to insurer:

> Mr. Muse is currently in treatment with me for Chronic Major Depressive Disorder and Chronic Pain Disorder, accompanied by severe stress due to his physical disability caused by a work-related injury in 1987. Secondary to these conditions and the medications he is prescribed, he also suffers from sexual dysfunction. I recommend that his Viagra medication be approved for coverage under his workers compensation.

(*Id*. at 10).

On August 14, 2001, Dr. Andrew Hurayt was deposed. (CX 40). He did not have Dr. Friedman's records, or Sunbelts', as Dr. Friedman had suffered an acute illness. (*Id*. at 7-8). He first examined Claimant for treatment purposes on March 20, 2000. (*Id*. at 8). Claimant was referred to Dr. Hurayt after Dr. Friedman became ill. At that point he reevaluated Claimant, did an initial psychiatric evaluation and took a history. (*Id*. at 9). He stated that his normal practice is to continue the current medication if the patient is doing well on it and that that is what he did with Claimant. (*Id*.).

Dr. Hurayt was asked what, besides the history given to him by Claimant, he based his opinion that his psychiatric condition was entirely due to the stress and disability of his 1987 work-related injury on, and replied:

> Well, if you'll look at the second page of my initial evaluation on Axis 1, diagnostic ... Depression, bipolar type, with significant situation. Antecedents, chronic pain syndrome. So you know, I was satisfied that that was his diagnosis.

(CX 40 at 11). All of this was based on what Claimant reported, he had no other medical information or doctors' reports at that time. (*Id*. at 12). He agreed that if he was given an incorrect history it could impact the diagnosis. (*Id*.).

Dr. Hurayt agreed that Claimant did not tell him many of the things in his record, such as Dr. Fipp's opinion that his 1987 injury was a temporary aggravation, and that he gave every indication that his condition was not discovered until well after his injury. (CX 40 at 16-19). In addition, Dr. Hurayt's written statement that Claimant "became depressed in the late '80s when

he was unable to work and had chronic pain and also lost a second job with Lockheed due to this hip injury and inability to ambulate" was questioned. (*Id*. at 19). He responded: "It doesn't appear that I specified any length of time, nor was I particularly interested at the time in whether he was or he wasn't.... So I would say, no, I didn't know one way or the other." (*Id*. at 20-21). He agreed that Claimant did not tell him that he got fired from Lockheed for stealing from the company and for threatening a fellow employee. (*Id*. at 21). At the time he did not discuss with the doctor his settlement of his claim against Lockheed, which, according to counsel "involved not only carpal tunnel syndrome in both wrists, but also this injury, second injury I was telling you about earlier that occurred during the work-hardening program in 1995." (*Id*.). He also did not tell him that the permanent disability ratings in both of his arms was due to carpal tunnel syndrome. (*Id*. at 22). He initially did not mention the post traumatic stress disorder from Vietnam, although subsequently, the day before the deposition, he did. (*Id*.). He was not aware that when he first started treating Claimant that he was still under the care of the VA psychiatrist for his post traumatic stress disorder condition and was receiving medications from them, although he has since seen a list of those medications. (*Id*. at 22-23). He did know Claimant was getting some medicine from the VA, in fact, he testified that some of that was medicine that he had prescribed for him as a way of obtaining a benefit. He stated: "I have many patients that are veterans that receive their medications through the VA. What they require is that you see their psychiatrist and usually they will go along with whatever they are being prescribed." (*Id*. at 23-24).

Based upon the previously unknown information given to Dr. Hurayt at the deposition, the following exchange occurred:

> Q: ...Is it more correct to say that his hip condition, no matter what the cause, is a contributing factor to his depression and his chronic pain disorder as opposed to simply saying it's all related to his 1987 hip injury, based on this additional information that I've given you?
>
> A: Well, again, my opinion is that the injury provided a significant source of stress and that prior to that time, again, given the information I have, he did not have psychiatric– significant psychiatric history and that he deteriorated since that time. Now, if that is true, then I would still stand by the idea that the accident then the subsequent surgery and pain and employment difficulties were probably secondary or exacerbated by that accident. But, again, I'm operating under the information that I have.
>
> Q: Okay. But if the underlying condition was a condition which preexisted this– and the facts show that that is in fact the case, that he had this preexisting neurosis–necrotic condition in his hip which was discovered by x-ray after he had this–...necrosis...it was a condition which apparently was just waiting to be discovered–
>
> A: Or was exacerbated by the accident. So if somebody had a fragile hip and then they fell, they would perhaps be more vulnerable. But perhaps if they had not had that particular accident, then perhaps they could have been tooling along. This

fellow was an Army Ranger. He was very active. So apparently at one point he was a healthy individual and he was I think still functioning in the Reserves. You know, he was a big man. He was probably 240 pounds. He couldn't be bouncing around with the Army Rangers if that hip had been that bad. I mean, this is just– again, I'm not an expert, but I can't imagine how that would happen. So when the necrosis occurred, I don't know. You know, could have been–sometimes those things can deteriorate pretty quickly.

Q: Not in four days.

A: Well, if there is no blood supply– I don't know. You would have to ask a pathologist, you know, who had expertise in that area. .. But if there is no blood supply, for example, if a blood supply gets interrupted, I'm not going to smell real good. If I'm dead after four days, I'm going to look poorly.

Q: Well, the doctor who operated on him said it was only a temporary aggravation of this underlying condition which they discovered on x-ray. And it was over a year after that before he had to have an operation. And during that time, he left his work at my client and went to work at Lockheed and worked for them February until January.

A: Well, I don't mean to argue with you, but the way that I understand the story as he's told me, he had pain, but he continued to function because he wanted to provide for his family. .. And that – so he continued to function with a dysfunctional hip joint the best he could. And what I thought happened was that because of the pain and his inability to function as he used to, that his mood deteriorated and he became grumpy and angry the way people will when they have chronic pain and things aren't going well. And particularly for a big, physical guy like this who can, you know, lift the back end of a pickup truck, for them not to be able to get around the way they used to can have some – is very difficult to tolerate. So my thought was that perhaps, you know, that these injuries were not adequately diagnosed. And again, that was my impression. I'm not saying that that's the truth, that's – you fellows are better at finding that out than I am. But my impression was that the thing wasn't fully diagnosed for one reason or another and he continued operating and then finally when they got a feeling for how serious this was and did the operation and it took– it was some time between that injury.

(CX 40 at 28-30). However, the doctor was corrected as counsel pointed out that Dr. O'Connell testified that he had long discussions with Claimant from the beginning that this was a long-term situation, and that he might have to have a hip replacement. (*Id*. at 30). He also pointed out that from 1992-1995 Claimant was not on any medications that he was aware of, even psychiatric. (*Id*. at 30-31).

Counsel described Claimant's condition from 1995 on, stating that before then he did not have a problem prior to that, and that he found it "incredible" that Claimant did not tell the doctor

about this or that it was not a factor to be considered in determining whether or not that was one of the underlying causes of his depression. (CX 40 at 31-32). Dr. Hurayt testified:

> Well, my concern with my patients is much more how they are currently functioning with their families and – than it is what caused what. And in terms of treating the patient, that's not tremendously important. So as far as I'm concerned, Roland has been pretty stable psychiatrically since I've been treating him. We have made some modifications in his medication regimen and I think his depression and mood swings have been controlled. He's not addicted to any kind of medication, has handled his medicines well and not abused them. His family seems to be stable. And again, those are my primary – I understand are jobs are just different jobs. You're trying to figure out what happened when and what's related. I'm not much interested in that. I'll do my best to help you, but to me that's not – that's not what I'm thinking about when I'm with him.

(*Id*. at 32-33). The doctor was then asked if, assuming everything in Claimant's history revealed or discussed thus far was true, or even the majority of it was true, would it be more correct to say that his psychiatric condition is due to the post total hip replacement and not necessarily related to a particular work-related injury. (*Id*. at 34). He replied:

> Well, I guess what I would think is that if he did have an accident in 1987 and that was the beginning of his hip trouble, then I would stand by my statement. The hip surgery was an attempt to rectify the damage that was done. And apparently there are still problems with his hip. He still has trouble with that hip, walks with a cane. So none of what I've heard from you has really changed that. Now, it took a while for the psychiatric problems to appear. And that's understandable as well, because it takes a while for those stresses to impact on a person's personality and ability to function. So I'm not – I wouldn't be willing to stipulate that it had to do with the surgery or the other accident. I mean, if it's true that the man had an accident in 1987, that he had damage to that hip joint, that that caused pain, diminished ability to function, financial stress, limits on what he could do, I would think that that is what did it. And I'm assuming that he hadn't had extensive psychiatric treatment or illness. ...

(*Id*. at 35). Claimant's PTSD was also discussed. (*Id*. at 36). He agreed that it could certainly be traumatic to be accused of stealing, being fired, and having an incident at work-hardening. (*Id*. at 37). He agreed that that would certainly contribute to Claimant's depression, and given what he was told during the deposition, he would agree with that. (*Id*. at 38).

Dr. Hurayt was asked if it was correct that he was not aware Claimant had PTSD until the day before the deposition. (CX 40 at 40). He stated that, he considered the possibility that he had some symptoms of PTSD but, in his opinion, "if someone isn't having significant and specific flashbacks, it's better to let sleeping dogs lie." (*Id*.). Claimant was on a number of medications that seemed to be working, he had satisfactory relationships, and he was self-monitoring. (*Id*.). He then stated: "So I figured it was good enough for government work, so to speak." (*Id*. at 41).

Dr. Hurayt also described some of the medications Claimant was on: Gabapentin/Neurontin- decreases irritability, stabilizes mood and diminishes pain (CX 40 at 41-42); Wellbutrin, an antidepressant (*Id*. at 42); Depakote 5000, like Neurontin but eliminated by the liver instead of the kidney and is a mood stabilizer, helps with neurogenic pain- calm, function (*Id*. at 43); Clonazepam, slow acting tranquilizer (*Id*.); Ambien, sleep (*Id*.); Viagra (*Id*.). Axid is for his upset stomach. (*Id*. at 44). He stated that propoxyphene, a pain control drug, was not being used because they were getting adequate pain control without it. (*Id*. at 42).

To his knowledge, Claimant was not working at the time of the deposition. (CX 40 at 48). When asked: "if you ignore any of the other problems that [Claimant's] having, his carpal tunnel condition, his posttraumatic stress disorder, and you only consider his hip condition and his depression, is there anything that would prohibit him from being able to return to work?" He replied:

> Well, that's really a question for someone who is specialized in physical disabilities. In my opinion psychiatrically, he is not disabled. He has some problems, but they appear to be adequately controlled.

(*Id*. at 49).

Dr. Hurayt was also asked about his June 1 note, which stated that Claimant was doing very well. (CX 40 at 51). Although the doctor did state that his condition had something to do with his financial status, Claimant did not mention his settlement check from Lockheed. (*Id*. at 51-52). He testified that he did not expect him to tell him that, and wouldn't remember if he had. He stated: [F]rankly, I hadn't thought of lowering his anxiety by obtaining money for him. I was trying to use antianxiety drugs. So, you know, we just didn't talk about money during the thing, except for when he would worry about, "gee, I can't pay this bill, I can't pay that bill." (*Id*. at 52). He stated Claimant's primary concerns lately have been the welfare of his children and his relationship with his wife, which he opines is also related to his pain and disability:

> I think that pain and disability can cause a man to feel less of a man. And some men, when they are feeling that way, then get – try and compensate by being in control. It may increase irritability and after a while people in your family just get tired of it. So there is an increased amount of divorce, an increased amount of drug abuse, alcohol abuse.

(*Id*. at 53). It is his understanding that Claimant has chronic pain syndrome in connection with the hip, the back and the wrist. (*Id*. at 55). He agreed that he mentioned nightmares in his notes but did not follow up on them. He stated:

> I guess sometimes he doesn't remember and the other thing is I guess my thought about posttraumatic stress disorder is that if it – if it keeps below a dull roar and you can function and you are not using drugs, it's better not to dig up that stuff. I think that – and some of these nightmares may not have been – they may have been dealing with a workman's comp.

(CX 40 at 57).

Dr. Hurayt diagnosed Claimant with "OC" or obsessive compulsive, thinking about the legal process. He stated, however, that he did not view that as pathological, just normal. (CX 40 at 59-60). He also diagnosed him as having a bipolar disorder. (*Id*. at 60-61). He was asked if it was "significant that the need for psychological treatment for the problems with his carpal tunnel...somehow disappeared after he had his settlement with Lockheed?" and replied:

> Well, I would say – again, I'm not familiar with all of the facts about that. He's getting psychiatric treatment, which is supportive in general, and has been with me and I guess before that with Dr. Friedman. And that treatment would have included – I mean, you don't divide up, well, this is for your knee and this is for your hip and this is for your wrist. I mean, you just – we're treating you for being sick and disabled and having some problems with that.

(*Id*. at 62). He was also asked if it was significant that Claimant no longer needed PTSD treatment after he started getting his VA disability pension and replied:

> Well, again, these medications would help to keep posttraumatic stress disorder under control. My guess is that if he has any posttraumatic stress disorder, and it's very probably that he has some symptoms, that these medicines would also be helpful for that.

(*Id*. at 62-63).

Dr. Hurayt was also asked about Dr. Fipp's opinion that Claimant's alcoholism caused his aseptic necrosis and not his 1987 fall, and replied:

> Says him. I wouldn't buy it. I've seen an awful lot of alcoholics, and I am an addictionologist and I don't see much aseptic necrosis secondary to alcohol. He's not sick enough to have aseptic necrosis from alcoholism. Has he ever been hospitalized for liver failure? [I don't know] Well, that would be an interesting question, because I wouldn't buy the assertion that alcohol caused the aseptic necrosis. I think that's a shot in the dark.

(CX 40 at 64). He agreed, however that alcoholism and cortisone/prednisone can be a contributing factor to Claimant's condition. (*Id*. at 64-65).

When asked if he planned to try and lower the number or amount of drugs Claimant is taking, Dr. Hurayt replied:

> And my plan for the future would be that, you know, to continue evaluating him as he comes in and reduce those drugs if it's possible to reduce them. We put him on smaller doses of Ambien, for example. Unless his condition gets better, he's probably going to continue to benefit from the Neurontin and Depakote and the

Wellbutrin probably indefinitely, and probably the Clonazepam.

(CX 40 at 69). He does not believe that psychotherapy in a more intensive nature would help reduce the amount of medication needed by Claimant. (*Id*. at 69-70).

Upon examination of his initial evaluation, Dr. Hurayt made some corrections– Claimant did tell him he was fired from Lockheed after being accused of stealing, and did not state that Dr. Miller was his family doctor. (CX 40 at 72-73).

Dr. Hurayt opined that Claimant needs continued treatment, including continued medications. (CX 40 at 76). He stated that in his opinion the medications that he is prescribing are related, in part or entirely, to his 1987 injury. (*Id*.). He explained that the Viagra is also related as:

> [T]he patient is on a significant number of mood stabilizers that are sedating and has a significant amount of anxiety. My guess is that the – those are adversely influencing his capacity to function sexually and that the Viagra has allowed him to function more fully as a man in his marriage and thus takes some of the strain off and makes things more comfortable for him and for his wife.

(*Id*.). When asked: "[C]an you rule out the injury to his hip and the surgery – or the hip replacement as either the precipitating cause or a cause of the depression that he's – that he has?" Dr. Hurayt replied: "No I cannot." (*Id*. at 76-77).

Finally, Dr. Huryat was asked about claimant's weight, and stated:

> We've talked about the fact that he's going to need to watch his weight if he's got knee problems. And unfortunately the medications that we're using, particularly the Depakote, plus the restrictive movement caused by this mobility problems, make it very easy to put weight on. And so the less weight he's got on those joints, the better.

(CX 40 at 78).

Dr. Edward Andrew Sobolewski

On April 23, 1999 Claimant received his psychiatric initial assessment by Dr. Edward Andrew Sobolewski. His "workers comp psychiatrist has CA and retired." The doctor wrote:

> Patients problems began a after 3 tours in VN working in intelligence with special forces where he lost a fire team since then endures waxing and waning PTSD symptoms with some exacerbations related to occupational changes at 7 year intervals. Sought treatment in 1989 diagnosed with bipolar D/O and treated with antidepressants coupled with mood stabilizers. He feels may have been diagnosed with bipolar for insurance purposes.

(EX 6 at 28). It was noted that, in 1989, Claimant was diagnosed with bipolar by Dr. Friedman, and had two weeks in New Horizons for a nervous breakdown. (*Id*). His diagnosis was then noted as follows:

Axis I: 1/ No bipolar disorder
2/ PTSD with depression/ panic attacks w agoraphobia
3/ Chronic pain with depression
4/ Medication induced memory disorder
5/ Nicotine use D/O
Axis II: defered [sic]
Axis III: As per medical eval;
Axis IV: Occupational/ legal problems, financial. (EX 6-29).

In a psychiatric progress note dated May 28, 1999, Dr. Sobolewski noted "Patient with wife reports fewer panic attacks, less depresse [sic] mood, affect congruent, still troubled by symptoms of PTSD, pain about the same no adverse med effects, has med f/u today. Rare use unknown med from PMD to abort panic attacks will bring next visit cautioned on use." (EX 6 at 27). He further noted "PTSD with depression and panic disorder with Agoraphobia complicated by chronic pain improving." (*Id*.). In a progress note dated August 13, 1999, Dr. Edward Andrew Sobolewski noted, in pertinent part:

1/ PTSD with depression improved
2/ Panic attacks assymptomatic
3/ chronic pain

(EX 6 at 26).

Dr. Juan Miller

In a letter to an insurance adjuster dated May 13, 1999, Dr. Juan Miller, of Sanchez, Miller, Quinones, M.D. & Associates, P.A., discussed his independent psychiatric evaluation of Claimant dated May 11, 1999. (EX 29). Dr. Miller briefly reviewed Claimant's employment, medical, military and family details. He wrote that Claimant has had prior history of depression during the time that he had his hip replacement. He was treated with Prozac for about a year, returned in 1994, with the additions of Viagra and anxiety medications. (EX 29 at 1). He wrote that Claimant reported he had been diagnosed with Bipolar Disorder and Obsessive Compulsive disorder. (*Id*.). His diagnostic impression was:

Axis I: Major Depression, recurrent severe
Rule out Bipolar disorder
Axis II: No diagnosis
Axis III: Chronic pain
Axis IV: Psychological stressors: level 3
Axis V: GAF - Current: 60

(*Id*. at 2). The doctor noted that the diagnosis was made based on the history provided by Claimant, and he received no medical records to review. (*Id*.). At this time his recommendations

included the statement: "I feel that the patient is in need of psychiatric treatment and I will be glad to continue his treatment." (*Id*.).

George N. Maida, Clinical Psychologist

On August 14, 1995 Claimant was seen at Associated Rehabilitation Services, Inc. for a work hardening psychological screening. (EX 20 at 8). The form used states that the purpose of this "limited assessment is to obtain insights into his psychological adjustment relative to his injury, and to aid in planning of his work hardening program only. It should not be construed as a complete psychological assessment." (*Id*.). In discussing his situation, Claimant "admitted to a sense of pessimism and despair." (*Id*. at 9). He also reported that he felt inadequate, cries, and breaks out in hives. (*Id*).

In reporting the results of objective testing, it was noted that, at this time, Claimant was frequently tense and anxious, experiencing undercurrents of sadness and anger. (EX 20 at 9). In addition, he was "occasionally moody, anxious, and irritable. He feels that he has been mistreated and this has resulted in a pessimistic, negative outlook. He was fearful that he will be harmed by the inaptness of others and is inclined to react to events in an unpredictable, often overly emotional manner." (*Id*.). It continues:

> Regarding adjustment to daily life, the test results indicate that he experiences routine demands and responsibilities as often overwhelming. He views the recent past as full of personally significant problems which he feels somewhat helpless to resolve by himself. The extreme negativity and pessimism that is revealed, seems very much related to recent life experiences. He is also pessimistic regarding the future, regarding both medical and non-medical difficulties.
>
> There are strong indications of severe anxiety and moderate depression. His emotional turmoil has a potential to exacerbate the symptoms, impair vocational and physical rehabilitation attempts, and to make him vulnerable to secondary stress-related symptoms. In this regard, his complaints of hives is quite significance as this symptom is quite likely to be a physiological reaction to the stress he is now experiencing.

(*Id*. at 10). In the conclusions and recommendations section, it is noted that Claimant "is suffering intense emotional turmoil directly related to his industrial injuries." (*Id*.). Symptoms are discussed, including his quick reactions, and fear that he will not be able to return to his job or one of similar calabur or salary. It was recommended that he be put back on an anti-depressant, perhaps supplemented by an anti-anxiety medication. (*Id*. at 11). The report is signed by George N. Maida, Clinical Psychologist. (*Id*.). *See also* (CX 28 at 1-5)(duplicate submission).

In a letter dated August 31, 1995, Mr. Maida wrote:

> Client complained that initially his exercise program was very difficult, but since then he has altered his exercise therapy program and he is doing much better in the program. He is to avoid physical tasks that while within his capacity would hasten

> deterioration of his artificial hip, causing it to need replacement sooner than otherwise. Client expressed resentment regarding some indifference to employee's long learn [sic] health and safety. Seemed very focused on past events that brought him to the problems he has now. Tried to help in focus his attention to current challenges.

(EX 20 at 28); (CX 28 at 35). In a continuation of this review of progress notes, headed "team meetings" and signed by Claimant on August 31, 1995, it states "Have questioned twice daily walk as it causes extreme pain in right hip. ... the old program gave me the worst three days I've had in over five years. ..." (EX 20 at 33).

In his deposition, dated September 23, 1997, George Maida discussed his note of individual counseling where Claimant expressed that he felt the therapists did not care about his hip. (CX 29 at 17, 20). After discussing the fact that chronic pain can cause depression, the following exchange occurred:

> Q: Did you form any kind of opinion as to whether or not you felt that Roland Muse may have been predisposed to become more vulnerable to depression because of the hip injury he had and the – any of the problems he might have had from that hip that might have continued into 1995 when he was being treated at Associated Rehab?
>
> A: Well, see, I think typically – I don't know whether I specifically formed that conclusion about Roland. I can tell you that typically when somebody's had an injury, they've overcome it, and they've perhaps had surgery, as he had, you know, and then they go on, and they get back into some kind of employment; that a second injury is typically more devastating, arouses more anxiety, and more concern, and more despondency than the initial one. Because, you know, you have one injury, you overcome it. You think, well, I overcame that. Then you have another one. Then you start thinking, boy, you know, am I under a black cloud? What else is going to happen? You know, you start thinking, the gods are after me. So, yeah, I think that typically that his despondency, his concerns, his anxiety about my future, and his perception of his future employment options were clearly all colored by the fact that in addition to the wrist he had the hip. Because just on the surface – and this isn't a psychological interpretation of Roland – just, you know, clearly, I mean, at face value you can see that if somebody has some limitations associated with the wrist, that's going to rule out certain kinds of employment options. If he also has some limitations from a pre-existing hip problem, that's going to cause additional limitation and rule out additional options. So, you know, it's clearly related.

(CX 29 at 20-21).

Associated Rehabilitation Services, Inc

In an initial interview and plan from Associated Rehabilitation Services, Inc., by Jerry G.

Albert, dated August 14, 1995, it was noted that Claimant sustained carpal tunnel syndrome. (EX 20 at 1). Claimant expressed willingness to travel at least 50 miles for an appropriate job, as he was terminated by Lockheed and does not expect to return there. (*Id*. at 2). Claimant's everyday activities were summarized. He reported that he had "an artificial hip on his right side and he utilizes a cane. He reports he does not walk long distances due to his artificial hip problems. (*Id*.). Mr. Albert also reviewed Claimant's employment history (*Id*. at 4-5). He listed his transferable skills as: supervisory experience, blueprint reading skills; construction; spacial/mechanical aptitude; knowledge of dispatching; knowledge of criminal justice. (*Id*. at 5). The functional limitations discussed dealt with Claimant's hands. (*Id*.). In addition, Mr. Albert wrote: "Due to a right hip replacement he reports he cannot sit or stand for prolong[ed] periods. He cannot run. He has difficulty with squatting. He has difficulty with stair climbing. He reports a Dr. Proctor placed a limitation of 7 steps in climbing." (*Id*. at 6). Among the services listed as needed are: "occupational therapy; physical therapy; vocational testing; exercise circuit; psychological counseling and simulated job tracks...." (*Id*. at 7);(CX 28 at 9-15)(duplicate submission).

In a work specific occupational rehabilitation program, upper extremity, initial functional capacity evaluation, dated August 14, 1995, Claimant's abilities are listed, in pertinent part as:

> 1. Fair tolerance scores with reports of right shoulder, right elbow and right hip pain during testing.
> 2. Limited right hip range of motion (See musculoskeletal screening section)...

(EX 20 at 12). The rest deal only with his hands and wrists. (*Id*.). Claimant reported his activities of daily living, stating that he is independent in self care activities, walking with a straight cane. He is unable to do yard work or home repairs. (*Id*.). In pertinent part, the recommendations included:

> perform[ing] functional activities within the work specific occupational rehabilitation program with the appropriate body mechanics, hand object activity, activity modification skills, and proper employee behavior skills... identify[ing] and accept[ing] his inappropriate illness behaviors and coping skills which he will receive from inter-disciplinary team to improve his worker role behaviors...empower[ing] himself with the independent daily performance of functional activities, individualized exercise circuits, lifting circuits and positional tolerance circuits...[and] explor[ing] vocational opportunities within his functional and transferable skills capabilities with certified vocational counselor.

(*Id*. at 13). Finally, it is noted that, based on the tolerance scores, Claimant could not return to his former occupation, as his condition falls in the light-medium level. (*Id*.).

In a letter to Dr. Freeman dated August 20, 1995, George Maida explained that he performed a psychological evaluation of Claimant in connection with his work hardening program, and that that assessment "indicates that he is still very depressed, and also very anxious." (EX 20 at 26). He wrote:

> His emotional turmoil is such that it is likely to negatively effect physical as well as vocational rehabilitation, as well as make him vulnerable to a variety of secondary stress-related disorders including cardiovascular symptoms, gastro-intestinal symptoms, and allergic disorders.

(*Id*.). He then recommended putting Claimant back on Prozac and perhaps anti-anxiety medication. (*Id*.). This sentiment is echoed in a note to Dr. Mark Lemel, dated August 24, 1995. (*Id*. at 27); (CX 28 at 6).

On September 8, 1995, Claimant was discharged from Associated Rehabilitation Services, Inc. His diagnosis, strengths, abilities, needs, preferences, desired outcomes and expectations established as well as the services provided were summarized. (EX 20 at 60-61). Inconsistencies were noted in Claimant's unwillingness to carry light objects during testing, and then carrying his project afterwards with no significant complaints. It "makes the rehabilitation team wonder as to Mr. Muse's motivations." (EX 20 at 62);(CX 28 at 18-22). In a typed version of the notes summarized *supra*, the note dated September 8, 1995 by RN noted increasing problems with Claimant after his September 5, 1995 appointment with Dr. Lemel. The note states:

> He took the project [shelves] home almost completed. He completed his final FCE, and was asked his pain level during each activity. He was "unable" to carry a crate empty, 30 ft. because of the reliance on his cane. I report seeing him walk without it before but today he couldn't guarantee he wouldn't fall. He was seen loading up his truck with his project 15 minutes after testing, carrying 4 shelves, 2 in each hand walking from garage without the use of his cane. Another client was present assisting him with the larger cabinet. There were no facial grimacing or rubbing his shoulder or elbow as he had earlier during the testing.

(EX 20 at 44). On September 8, 1995 Claimant was discharged. His psychological discharge summary reads:

> Patient to be discharged because he has completed program. Has improved emotionally. Recommended to his physician that anti-depressant medication be considered. This was found helpful in the past and he seems to need medication again.

(CX 28 at 8).

Mr. Albert was asked if Claimant ever reported an injury, on a leg extension machine. He replied: "Not to me. Nothing that I recall relative to that." (CX 30 at 13). When asked what the appropriate reaction to such an event, if it was reported, Mr. Albert replied "[t]o create an incident report, and send him to his doctor. ...or to the hospital." (*Id*. at 13-14). He stated, however, that he had no reason to believe that Claimant was injured while going through the program. (*Id*. at 15).

Ms. Upton, an employee of Associated Rehabilitation who worked with Claimant, was also asked if he reported an injury during his therapy she replied, in pertinent part:

> He did mention once that he – his hip was bothering him, but not to the point that – I'm one, who's, having been a nurse for 13 years, am a stickler about incident reports. And he did not indicate to me any extreme difficulty with his hip other than the machine bothered him. And I told him I would talk to the occupational therapist about the [hydraulic total power] machine, and eliminating it from his program.

(CX 31 at 11-12). She also reviewed Claimant's notes of the 24th and testified:

> And that's when he explained to me that he felt he was overly doing it. I don't recall him making an extreme issue. If it was an issue, I would have written up an incident report. ... And the fact is that he had the choice, and he always had the choice, to continue and stay for the day if he was uncomfortable. He chose not to leave. In fact he stayed 8.3 hours that day.

(CX 31 at 25-26).

Section 20(a) Presumption

Section 20(a) of the Act, 33 U.S.C. § 920(a), creates a presumption that a claimant's disabling condition is causally related to his employment. In order to invoke the § 20(a) presumption, a claimant must prove that he suffered a harm and that conditions existed at work or an accident occurred at work that could have caused, aggravated or accelerated the condition. *Merrill v. Todd Pacific Shipyards, Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Building Co.*, 23 BRBS 191 (1990). A claimant's credible subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a *prima facie* case and the invocation of the § 20(a) presumption. *See Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom, Sylvester v. Director, OWCP*, 681 F.2d 359 (5th Cir. 1982).

To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128 (1984); *Kelaita, supra*. Once this *prima facie* case is established, a presumption is created under § 20(a) that the employee's injury or death arose out of employment. *Kier, supra*. Courts and the Board have also indicated that when an underlying condition is rendered symptomatic, a compensable "aggravation" has occurred and the entire resulting disability is compensable. *See Cairns v. Matson Terminals, Inc*. 21 BRBS 252, 257 (1988); *Gardner v. Bath Iron Works Corp*., 11 BRBS 556 (1979), *aff'd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981). In addition, the natural progression of Claimant's condition is compensable, unless the causal chain is broken by subsequent injury. *Delaware River Stevedores, Inc. v. Director, Office of Workers' Compensation Programs*, 279 F.3d 233 (3rd Cir. 2002). Once claimant establishes a physical harm and working conditions which could have caused or aggravated the harm or pain the burden shifts to the employer to establish that claimant's condition was not caused or aggravated by his employment. *Brown v.*

Pacific Dry Dock, 22 BRBS 284 (1989); *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986).

Hip Injury

As discussed *supra*, Claimant must prove that he suffered a physical harm and that an accident occurred in the course of employment. *Kier, supra*. The parties stipulated that an injury did occur, although the extent and nature of the injury is contested. *See* (JX 1 at 16). Therefore, it is uncontested that Claimant suffered an injury. Claimant's testimony also shows that he suffered an injury. He testified that, prior to his accident, he had had no problems with his hip. (TR. at 136, 138). He also testified that, after the accident, he had continuing pain and problems with his shin, knee and hip. (*Id.*). Claimant's testimony that he had not had problems with his hip prior to his accident and his testimony regarding his condition and pain after the accident is uncontested.

Therefore, it is undisputed that Claimant's avascular necrosis became symptomatic after his 1987 work-related accident. *See* (CX 7 at 39-40)(Dr. O'Connell) (CX 14 at 43-44)(Dr. Fipp). The medical evidence is consistent in determining that Claimant suffers from avascular necrosis and that the condition was asymptomatic prior to the November 6, 1987 injury. *See* (CX 7 at 25, 36)(Dr. O'Connell stating that Claimant suffered an aggravation to avascular necrosis);(EX 17 at 2)(CX 14 at 41-43)(Dr. Fipp stating same); (EX 26-1)(CX 22 at 7-8, 35)(Dr. Hardy);(CX 24 at 6)(Dr. Dargon noting Claimant's aseptic necrosis history); (EX 23 at 1)(Dr. Campbell noting Claimant's history of avascular necrosis). Finally, the medical evidence is consistent in stating that, due to Claimant's hip replacement at a young age, further replacements will be required due to a natural deterioration. *See e.g.* (CX 12 at 2)(Dr. Lykens stating that Claimant will need two or more hip replacements during his normal life span); (CX 7 at 14)(Dr. O'Connell stating that he anticipated a further hip replacement after the first). Therefore, Claimant has proven that he suffered, and continues to suffer, from pain in his hip and a hip injury.

The second element of Claimant's *prima facie* case consists of proving that an accident occurred. The parties have stipulated that Claimant had an accident on November 6, 1987 that arose out of and in the scope of his employment. (JX 1 at 3,4). Claimant's testimony describing the accident is uncontested. (TR. at 136). Therefore, Claimant has proven his *prima facie* case and the § 20(a) presumption is invoked. Accordingly, it is presumed that Claimant's hip condition was caused by, combined with, accelerated, or aggravated by his November 6, 1987 accident.

Psychological Injury

Claimant has also alleged a psychological injury resulting from the November 6, 1987 accident and his resultant physical injuries. A psychological impairment can be an injury under the LHWCA if work-related. *Director, OWCP v. Potomac Elec. Power Co. (Brannon)*, 607 F.2d 1378, 10 BRBS 1048 (D.C. Cir. 1979) (work injury results in psychological problems, leading to suicide); *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255 (1984) (benefits allowed for depression due to work-related disability); *Whittington v. National Bank*, 12 BRBS 439 (1980) (remand to determine whether stress and pressure at work aggravated psychiatric condition); *Moss v. Norfolk Shipbuilding & Dry Dock Corp.*, 10 BRBS 428 (1979) (although claimant's

anxiety condition is not an occupational disease, it is compensable as an accidental injury). The aggravation of a preexisting psychological problem also constitutes an injury. *Turner, supra* at 257.

As discussed *supra*, the parties have stipulated that an accident occurred, therefore, one element of Claimant's *prima facie* case is proven. The testimony of Mrs. Muse, Claimant's own testimony, and the medical evidence shows that Claimant does in fact suffer from psychological problems, including depression. Mrs. Muse, Claimant's wife, testified that after Claimant's 1987 injury Claimant developed unexplainable mood swings and could not deal with pressure. (TR. at 100-01). Mrs. Muse attributed this to "losing everything" due to his hip injury. (TR. at 100). From her point of view, Claimant is depressed and has anxiety that has not stopped since November of 1987. (TR. at 101-02). Claimant testified that he feels that his depression is the same type he had in the late 1980's and early 1990's when he was seeing Dr. Friedman and that the depression has not stopped since that time. (TR. at 156). The opinion of Dr. Hurayt attributes this, at least in part, to his workplace injury of November 6, 1987. (CX 39 at 2; CX 40 at 28-30, 35, 76). Claimant's therapist, Janet Gray, noted that Claimant reported his Vietnam flashbacks became more frequent and intense since his job related accidents. (EX 30 at 53, 49-50, 46). When admitted to New Visions Center for Health and Wellness in 1996, one of Claimant's noted stressors was "intense physical pain due to a total hip replacement operation." (CX 34 at 2).

Therefore, Claimant has established a prima facie case and the presumption of § 20(a) is invoked. Accordingly, it is presumed that Claimant's continuing psychological condition is caused by, combined with, accelerated or aggravated by his November 6, 1987, accident and resultant injuries.

Rebuttal of Section 20(a) Presumption

Once the presumption is invoked, the burden shifts to the employer to rebut the presumption with substantial countervailing evidence which establishes that the claimant's employment did not cause, contribute to or aggravate his condition. *James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989); *Peterson v. General Dynamics Corp.*, 25 BRBS 71 (1991). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. *E & L Transport Co., v. N.L.R.B.*, 85 F.3d 1258 (7th Cir. 1996). The Eleventh Circuit, under whose jurisdiction this case arises, has held that in order to rebut the § 20(a) presumption the employer must "rule out" the possibility of causation. *Brown v. Jacksonville Shipyard, Inc.*, 893 F.2d 294 (11th Cir. 1990). Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by § 20(a). *See Smith v. Sealand Terminal*, 14 BRBS 844 (1982). Rather, the presumption must be rebutted with specific and comprehensive medical evidence proving the absence of, or severing, the connection between the harm and employment. *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990). When aggravation of or contribution to a pre-existing condition is alleged, the presumption still applies, and in order to rebut it, Employer must establish that Claimant's condition was not caused or aggravated by his employment. *Rajotte v. Genera Dynamics Corp.*, 18 BRBS 85 (1986).

Hip Injury

In order to rebut the presumption that the 1987 accident caused, aggravated, combined with or accelerated Claimant's hip condition, Employer argues that Claimant's 1987 injury at work was only a contusion of the hip, a temporary or trivial injury and so is not a factor in any permanent condition from which the Claimant suffers. In support of this position they rely on the medical records and testimony of Drs. Fipp, Campbell, and Proctor. (Emp. Br. at 7-10).

Dr. Fipp opines that Claimant's x-rays show "aseptic necrosis of the right hip with continuing collapse since the first x-ray of November 7, 1987." (EX 17 at 1-2). He further states: "I feel this patient has aseptic necrosis of the right hip. I feel the fall was a temporary aggravation of a pre-existing condition." (*Id*. at 2). He is firm in his opinion that Claimant's asesptic necrosis was not caused by his accident of November 6, 1987, due to the progression of the disease. (CX 14 at 13, 11, 18-19). He did, however, agree that Claimant's condition was asymptomatic prior to November 1987, and testified that it was a possibility that the accident acted as a "triggering device" for Claimant's symptoms. (CX 14 at 41-43). Further, while Dr. Fipp stated that he could rule out the possibility that the accident was the cause of Claimant's disease, he could not rule out the possibility that the accident caused the symptoms that he presented to him with and the need for surgery. (CX 14 at 43). Therefore, while Dr. Fipp's testimony and records do constitute substantial evidence that Claimant's aseptic necrosis was not caused by his accident, it is not sufficient to rule out or sever the relationship between the aggravation of Claimant's aseptic necrosis and the onset of symptoms and Claimant's 1987 accident. Dr. Fipp's medical assessment that Claimant's condition was "temporary" is in contradiction to his testimony that Claimant's accident may have been a "triggering device" for Claimant's symptoms. Therefore, he does not unequivocally opine that Claimant's November 6, 1987 accident did not aggravate or accelerate his preexisting condition.

In his deposition, Dr. Campbell stated that avascular necrosis was a condition that took years to develop and that it is absolutely not a condition that could occur over days. (CX 19 at 19). He noted that Claimant's condition was first noted almost immediately after his November 1987 accident. (*Id*.). Dr. Campbell agreed with Dr. Fipp's opinion that Claimant's avascular necrosis was unrelated to his accident. (*Id*. at 20). When asked, however, if Claimant's 1987 injury was just a temporary aggravation of that condition, he replied that "possibly" it was, or perhaps it could have been "microfracturing" of the bone. (*Id*.). *See also* (*Id*. at 41)(stating that he "tend[s] to concur" with Dr. Fipp's opinion that Claimant's 1987 injury was basically soft tissue, with the caveat that it could have been a microfracture). Dr. Campbell added: "certainly an impact-type job could hasten the onset of symptoms. But it certainly isn't the etiology of the underlying condition." (*Id*. at 40-41). Dr. Campbell's testimony is unequivocal that Claimant's avascular necrosis was not caused by his accident, however, it is equivocal as to whether or not the accident accelerated, combined with or aggravated the underlying condition. Therefore, Dr. Campbell's testimony is insufficient to rebut the presumption as it does not rule out the possibility that Claimant's work-related 1987 accident aggravated his pre-existing condition and so does not sever the causal connection.

In addition, Employer asserts that Dr. Proctor's records, dated February 10, 1988, states "Normal exam except... recent [right] hip injury now asymptomatic." (Emp. Br. at 6-7). In fact,

the record, filled in by Claimant states that he "feels only minor ocs discomfort" in his hip. (EX 18 at 1). Dr. Proctor's notes are handwritten and partially illegible. The court can make out the following: "Normal exam except 1. recent R [covered by a stamp but appears to start with an A or an O] injury now asymptomatic; 2. elev [covered by stamp] ..." (EX 18 at 1). Further, Dr. Proctor notes that Claimant has had a recent hip x-ray - "WNL" and Claimant did not check any box on the questions inquiring about problems with "any nerve, muscle, bone disease" or and of the questions regarding skin disorders, rashes, scales, itching, ulcers; blistering, peeling, weeping; skin hives, allergy to bugs/ chemicals. (EX 18 at 2). This evidence does not constitute substantial evidence sufficient to rebut the presumption.

Employer has not produced substantial evidence severing the causal connection between Claimant's avascular necrosis and his 1987 work injury. Although the medical evidence presented indicates that Claimant's condition was not caused by his accident, it does negate the possibility that Claimant's preexisting condition was aggravated or accelerated by his work-related accident. Therefore, the § 20(a) causal presumption is not rebutted, and it is established that Claimant's 1987 work-related accident aggravated or accelerated his preexisting condition.

In fact, it is uncontested that Claimant's symptoms did not begin until his 1987 accident. As discussed *supra*, when an underlying condition is rendered symptomatic, a compensable aggravation has occurred and the entire resulting disability is compensable. *See Cairns v. Matson Terminals, Inc*. 21 BRBS 252, 257 (1988); *Gardner v. Bath Iron Works Corp*., 11 BRBS 556 (1979), *aff'd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981). Accordingly, I find that Claimant's 1987 work-related accident aggravated his preexisting hip condition and therefore Employer is responsible for the entire resultant disability. *See Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986)(holding that where an employment-related injury aggravates, combines with, or accelerates a pre-existing condition, the entire resultant condition is compensable).

Subsequent Injury as Rebuttal, Severing the Causal Connection

Another issue in this case is whether any disability herein is casually related to, and is the natural and unavoidable consequence of, Claimant's work-related accident or whether a subsequent injury constituted an independent and intervening event attributable to Claimant's own intentional or negligent conduct, thus breaking the chain of causality between the work-related injury and any disability he may now be experiencing.

The basic rule of law in "direct and natural consequences" cases is stated in Vol. 1 *Larson's Workmen's Compensation Law* §13.00 at 3-348.91 (1985):

> When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent intervening cause [event] attributable to claimant's own intentional conduct.

Professor Larson writes at Section 13.11:

> The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.

The simplest application of this principle is the rule that all the medical consequences and natural sequelae that flow from the primary injury are compensable . . . The issue in all of these cases is exclusively the medical issue of causal connection between the primary injury and the subsequent medical complications. (*Id.* at § 13.11(a))

This rule is succinctly stated in *Cyr v. Crescent Wharf & Warehouse*, 211 F.2d 454, 457 (9th Cir. 1954) as follows: "If an employee who is suffering from a compensable injury sustains an additional injury as a natural result of the primary injury, the two may be said to fuse into one compensable injury." *See also Bludworth Shipyard, Inc. v. Lira*, 700 F.2d 1046 (5th Cir. 1983); *Mississippi Coast Marine, Inc. v. Bosarge*, 632 F.2d 994 (5th Cir. 1981), *modified*, 657 F.2d 665 (5th Cir. 1981); *Hicks v. Pacific Marine & Supply Co.*, 14 BRBS 549 (1981).

Once the work-connected character of any injury has been established, the subsequent progression of that condition remains compensable as long as the worsening is not shown to have been produced by an independent or non-industrial cause. *Hayward v. Parsons Hospital*, 32 A.2d 983, 301 N.Y.S.2d 649 (1960). Moreover, the subsequent disability is compensable even if the triggering episode is some non-employment exertion like raising a window or hanging up a suit, so long as it is clear that the real operative factor is the progression of the compensable injury, associated with an exertion that in itself would not be unreasonable in the circumstances.

However, a different question is presented when the triggering activity is itself rash in the light of claimant's knowledge of his condition. The issue in all such cases is exclusively the medical issue of causal connection between the primary injury and the subsequent medical complications, and denials of compensation in this category have invariably been the result of a conclusion that the requisite medical causal connection did not exist. *Matherly v. State Accident Insurance Fund*, 28 Or. App. 691, 560 P.2d 682 (1977). A weakened member was held to have caused the subsequent compensable injury where there was no evidence of negligence or fault. *J.V. Vozzolo, Inc. v. Britton*, 377 F. 2d 144 (D.C. Cir. 1967); *Carabetta v. Industrial Commission*, 12 Ariz. App. 239, 469 P.2d 473 (1970). However, the subsequent consequences are not compensable when the claimant's negligent intentional act broke the chain of causation. *Sullivan v. B & A Construction, Inc.*, 122 N.Y.S.2d 571, 120 N.E.2d 694 (1954). If a claimant, knowing of certain weaknesses, rashly undertakes activities likely to produce harmful results, the chain of causation is broken by his own negligence. *Johnnie's Produce Co. v. Benedict & Jordan*, 120 So. 2d 12 (Fla. 1960).

In the instant case, Employer alleges Claimant suffered two subsequent injuries which should break the chain of causation between his initial injury and his current condition, thereby severing the connection between the 1987 accident and Claimant's condition and rebutting the presumption as of the date of the subsequent injury. According to Employer, Claimant suffered a new injury to his hip in 1988 and again in 1995 which would relieve it of further liability and

indicate a later responsible employer.[17] (Emp. Br. at 12).

Employer argues that Claimant was injured while on reserve duty in March of 1988. They base this assertion on Claimant's application for disability compensation or pension to the Department of Veterans Affairs on July 19, 1999. (Emp. Br. at 13). Employer also points to the progression of Claimant's hip condition from February to April as evidence of an injury. (*Id*.). This assertion is sheer speculation. Claimant never reported an injury to any medical doctor, no medical evidence or doctor's opinion supports this assertion. In addition, VA Representative Terry Smith credibly testified that Claimant did not see the VA form for benefits before it was sent in, that he filled the form out for Claimant, and that Claimant's account was jumbled, ran together, and was hard to understand. (TR. at 80-86). He further testified that there was a possibility that he may have misunderstood the information given by Claimant. (*Id*. at 83).

Therefore, I find that Employer has presented no evidence of a subsequent injury while on active reserve duty, merely speculation, and as such, the causal connection between the 1987 injury and Claimant's condition has not been severed.

Finally, Employer alleges that Claimant suffered a subsequent injury in August of 1995, while in physical therapy at Associated Rehabilitation Services for a separate and distinct wrist injury which occurred while Claimant was working for a later employer, Lockheed. (Emp. Br. at 15). This allegation is based upon Claimant's account of being asked to perform a leg lift using a hydraulic machine, which caused a popping noise and pain. (TR. at 152-154). According to medical records, Claimant continuously referred to this as an injury and repeatedly sought medical attention for the increased pain. (CX 29 at 18-19)(Dr. Maida); (EX 24 at 4-5), (EX 13)(Dr. Dargon); (EX 22 at 1)(Dr. Lemel);(EX 21 at 1)(Dr. Bahri);(EX 23 at1)(Dr. Campbell); (EX 26 at 1)(Dr. Hardy). However, the medical evidence also shows no objective evidence of a subsequent injury or a change in the condition of Claimant's hip, other than his subjective complaints of pain and popping. (TR. at 155)(Claimant testifying that no doctor has told him that his right hip is worse since the work hardening incident). There has been no increase in his work restrictions since August 1995. (*Id*. at 155). In addition, the alleged incident occurred while Claimant was in physical therapy, under the care of medical personnel, not during work. While, according to *Delaware River Stevedores, Inc. v. Director, Office of Workers' Compensation Programs*, 279 F.3d 233 (3rd Cir. 2002), an increase in pain, or "flare up" of a chronic pre-existing condition can shift the liability between employers, in the instant case, Claimant was not at work when this incident occurred. Rather, he was following the instruction of medical personnel. As such, his behavior was not reckless or negligent, therefore the incident does not constitute an intervening injury. The consequences are compensable when a weakened body member contributed to a later injury. *See Leonard v. Arnold*, 218 Va. 210, 237 S.E.2d 97 (Va**.** 1977). A weakened member was held to have caused the subsequent compensable injury where there was no evidence of intentional or rash action on the part of the claimant. *J.V. Vozzolo, Inc. v. Britton*, 377 F.2d 144 (D.C. Cir. 1967); *Carabetta v. Industrial Comm'n*, 12 Ariz. App. 239, 469 P.2d 473 (Ariz. Ct. App. 1970). Finally, as discussed *supra*, Claimant testified that, since his 1987 accident, he has continuously experienced pain. Therefore I find that Employer has not proven that a subsequent

[17] As no subsequent employers are parties to this case, Employer alone bears the burden of proving that by a preponderance of the evidence that a subsequent injury with another employer. *See Buchanan* at 35-36.

injury occurred and so the § 20(a) presumption has not been rebutted.

Psychological Injury

As discussed *supra*, it has been stipulated that a work-related accident causing some injury occurred on November 6, 1987. (JX 1 at Stip. 3,4,& 16). It has been found that this accident aggravated Claimant's pre-existing hip condition, avascular necrosis. *See* discussion *supra*. It is undisputed within the medical evidence that Claimant's work related accident aggravated his preexisting psychological condition by contributing to his depression and through chronic pain syndrome. *See* (CX 35 at 1)(Dr. Friedman's initial diagnosis and treatment note nor anxiety, stress, dysthmia in 1989);(EX 30 at 54-56)(Dr. Friedman, noting Claimant's "past history is his 1989 depression treated with prozac and quit when he went back to work);(EX 30 at 53)(Janet Gray noting: "He was seen in our office back in 1989 after the first accident. Dr. Friedman administered Prozac and he discontinued this when he was able to return to work.");(CX 34 at 2)(Dr. Friedman's 1996 admission to New Visions stating "[Claimant's] current stressors include depression, post-traumatic stress syndrome, altercation with insurance agent for worker's compensation claim, and intense physical pain due to a total hip replacement operation and the carpal tunnel surgery.");(CX 39 at 2)(Dr. Hurayt stating: "I believe that his psychiatric condition is entirely due to the stress and disability of the 1987 work-related injury and its physical, emotional and financial ramifications.");(CX 39 at 10)(Dr. Hurayt's diagnosis of Chronic Major Depressive Disorder and Chronic Pain Disorder).

Employer has offered no evidence or argument to rebut this proposition other than attempts to limit the relevant time frame, which, as discussed supra, does not constitute an appropriate rebuttal. *See supra* note 13. *See also* discussion *infra*, nature and extent. (EX 30 at 54). Therefore, I find that Employer has not provided substantial evidence to sever the Claimant's 1987 injury as the cause or aggravation of his psychological problems, and the § 20(a) presumption is not rebutted.

Again, it must be considered whether an intervening event or subsequent injury occurred which will break the chain of causation. If there has been a subsequent non-work-related event, employer can establish rebuttal of the § 20(a) presumption by producing substantial evidence that the claimant's condition was not caused by the work-related event. *See James*, 22 BRBS 271. Thus, if the disability resulted from the natural progression of an earlier injury and would have occurred notwithstanding the presence of a second incident, then the earlier injury is compensable and the carrier on the risk as of that date is responsible for the benefits due the claimant. *Madrid v. Coast Marine Constr. Co.*, 22 BRBS 148, 153 (1989); *Wheeler v. Interocean Stevedoring*, 21 BRBS 33 (1988); *Crawford v. Equitable Shipyards*, 11 BRBS 646, 649-50 (1979), *aff'd sub nom. Employers Nat'l Ins. Co. v. Equitable Shipyards*, 640 F.2d 383 (5th Cir**.** 1981).

As discussed *supra*, the alleged incident in Claimant's 1988 Active Reserves has been found to be mere speculation, unsupported by medical evidence and insufficient to rebut the presumption. However, according to the medical evidence, Claimant did suffer a second injury while working for Lockheed which, while affecting a different body part, affected his psychological state. Claimant testified that the only doctor that treated him from 1991 until 1994 was Dr. Dargon, his family physician. (TR. at 196). Dr. O'Connell was the first to refer Claimant

to psychological counseling. He stated that Claimant reported being "psychologically down due to his time off and his problem with his hip and thinks he may need help...". (CX 6 at 6). He was referred to Dr. Sabo. (*Id*. at 11). On October 13, 1989, Dr. Friedman noted that he had been treating Claimant for dysthmia and anxiety. (CX 35 at 1). The next note is from April of 1990, when Claimant reported Lockheed was cutting employees. (CX 35 at 5). At that time, Claimant had been undergoing psychotherapy and the assessment was to continue. (*Id*.).

Claimant underwent no further treatment until 1995, when he was referred to Dr. Friedman by Dr. Lemel. (EX 30 at 54). At that time, Claimant dated his current depression as beginning Christmas of 1994, and that his past history is 1989 depression, treated with Prozac and quit when he went back to work. (CX 36 at 1-3); (EX 30 at 53). On September 5, 1995, Claimant was seen by Dr. Lemel who noted "mental anguish" and stated Dr. Dargon would "see about restarting him on some Prozac." (CX 26 at 12). *See also* (EX 6 at 21-22)(doctor stating that Claimant has a history of recurrent episodes of anxiety and depression since his 1994 discharge from Lockheed for stealing). The next note is from Dr. Dargon on September 11, 1995, where she reported that Claimant appeared "feeling sad, helplessness and inability to relax which began gradually several months ago. Risk factors for suicide include financial setback" (CX 24 at 24). On September 12, 1995, Dr. Mark Lemel noted that he believed Claimant was suffering from a "stress related depression" which may have been related to bad circumstances regarding his job [at Lockheed]. (CX 26 at 13).

Therefore, I find that Claimant's psychological problems due to the 1987 injury were resolved, and that by all accounts he discontinued treatment once he became employed by Lockheed and did not seek treatment again until after a subsequent injury to his wrists and his discharge for stealing. Employer has presented sufficient evidence to rebut the presumption that Claimant's current psychological problems were due to a second injury for a subsequent employer, thus severing the causal connection between his 1987 injury and his current condition.

Weighing the Evidence– Current Psychological Condition

Once the presumption of causation has been successfully rebutted, "the presumption no longer controls and the issue of causation must be resolved based on the evidence as a whole." *Devine v. Atlantic Container Lines, G.I.E.*, 25 BRBS 16, 20-21 (1990). This is what is commonly referred to as the "bursting bubble" theory of the § 20 (a) presumption. *Brennan v. Bethlehem Steel Corp.*, 7 BRBS 947 (1978). Therefore, it must be determined whether Claimant has shown by a preponderance of the evidence that the alleged aggravation of his psychological condition is causally related to his employment with Employer. In attempting to meet this burden, Claimant is not entitled to the so-called "benefit of the doubt rule." *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251, 28 BRBS 43 (CRT) (1994). Employer has rebutted the causal connection between Claimant's current psychological condition and his 1987 accident by showing a subsequent work-related injury which aggravated, combined with or caused his current condition.

To establish a causal connection between his current psychological condition and his 1987 accident, Claimant relies on the opinion of Dr. Hurayt, who stated:

> It should be noted that there is no history of psychiatric treatment or psychiatric illness prior to his work related injury in 1987. I believe that his psychiatric condition is entirely due to the stress and disability of the 1987 work-related injury and its physical, emotional and financial ramifications.

(CX 39 at 2). However, Dr. Huryat also testified that he based his opinion on what Claimant reported and that he had no other medical information or doctors' reports at that time. (CX 40 at 12). He also stated that, if given an incorrect history, his diagnosis would be effected. (*Id*.). Finally, Dr. Huryat agreed that Claimant did not tell him many of the things in his record. (*Id*. at 16-19). In addition, Dr. Huryat was unaware that, from 1992 through 1995 Claimant was on no medications, even psychiatric. (*Id*. at 30-31). Dr. Huryat also agreed that it would be traumatic to be accused of stealing, be fired and have an incident at work-hardening and that, based on what he was told during the deposition, he would agree that it would certainly contribute to Claimant's depression. (*Id*. at 37-38).

Due to the significant gaps in Dr. Huryat's knowledge of Claimant, and his admission that his diagnosis could be affected by that lack of information or incorrect information, I find his opinion entitled to little weight. Relying upon the contrary opinions of Dr. Friedman, Dr. Lemel and Dr. Dargon, I find that Claimant has not established that his current psychological condition is related to his 1987 injury or hip condition. Rather, I find that Claimant's psychological problems related to the 1987 injury were resolved and then aggravated or made symptomatic by the second injury, carpal tunnel syndrome, which occurred at a second employer, Lockheed. At that point the causal connection between Claimant's 1987 injury and his psychological condition was broken.

Medical Benefits

Where a claimant has demonstrated that he has suffered from a compensable injury under the LHWCA, the employer is required to furnish medical, surgical and other attendant benefits and treatment for as long as the nature of the recovery process requires. 33 U.S.C. § 907. The claimant must establish that medical expenses are related to the compensable injury and are reasonable and necessary. *Pardee v. Army Force Exchange Service*, 3 BRBS 1130 (1981); *Pernell v. Capital Hill Masonry*, 11 BRBS 532, 539 (1979). The medical expenses are assessable against the employer so long as they are related to the compensable injury. *See Pardee, supra.* The employer is liable for medical services for all legitimate consequences of the compensable injury, including the chosen physician's unskillfulness or errors of judgment. *Linsay v. George Wash. Univ.*, 279 F.2d 819 (D.C. Cir. 1960); *see also Austin v. Johns-Manville Sales Corp*., 508 F.Supp. 313 (D. Me. 1981).

The employer is liable for all medical expenses which are the natural and unavoidable result of the work injury, and not due to an intervening cause. For example, an employer must pay for the treatment of the claimant's myocardial infarction, if the judge finds that it is causally related to a prior work-related injury. *Atlantic Marine v. Bruce*, 661 F.2d 898 (5th Cir. 1981), *aff'g* 12 BRBS 65 (1980). Any injury sustained during the course of a medical examination scheduled at the employer's request for an alleged work-related injury is covered under the LHWCA, because such an injury necessarily arises out of and in the course of employment.

Weber v. Seattle Crescent Container Corp., 19 BRBS 146, 148 (1986). A doctor's treatment of a claimant does not constitute an intervening cause as there is no evidence on his part of either intentional misconduct or negligent conduct unrelated to the claimant's primary injury. *Wheeler v. Interocean Stevedoring*, 21 BRBS 33 (1988). (Improper, unauthorized medical treatment is not reimbursable). Further, the LHWCA's liberal concept of causation is applied to subsequent injuries as well as to initial ones. *Atlantic Marine, Inc. v. Bruce*, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981), *aff'g* 12 BRBS 65 (1980).

Treatment is compensable even though it is due only partly for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 258 (1984). In *Kelley v. Bureau of National Affairs*, 20 BRBS 169,172 (1988), the Board held that where relevant evidence established that the claimant's psychological condition was occasioned, at least in part, by her work injury, treatment received by the claimant for this condition was compensable under the LHWCA. Therefore, Claimant is entitled to ongoing medical benefits for orthopedic treatment of his hip and compensation for psychological treatment until his subsequent injury.

Nature and Extent of Injury

In the instant case, I have found that Claimant is entitled to income and medical benefits, for his orthopedic and psychological injuries from November 6, 1987 through 1994. Employer bears a continuing liability for Claimant's orthopedic injuries, however, due to a subsequent injury, their liability for Claimant's psychological injuries ends in 1994. It has been stipulated that Claimant is not seeking permanent total disability at this time, and that at the time of his injury his average weekly wage was $498.77. *See* (JX 1 at Stip. 14 b; 21). At the hearing it was also stipulated that Claimant is entitled to temporary total disability benefits from January 26, 1988 through February 22, 1988. (TR. at 26-27).

Nature of Disability

Permanent disability is a disability that has continued for a lengthy period of time and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, *pet. for reh'g denied sub nom. Young & Co. v. Shea*, 404 F.2d 1059 (5th Cir. 1968)(per curium), *cert. denied*, 394 U.S. 876 (1969). In such cases, the date of permanency is the date that the employee ceases receiving treatment, with a view toward improving his condition. *Leech v. Service Eng'g Co.*, 15 BRBS 18, 21 (1982). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56, 60 (1985). Any disability suffered by Claimant before reaching maximum medical improvement is considered temporary in nature. *Berkstresser v. Washington Metro. Area Transit Auth.*, 16 BRBS 231 (1984).

In the instant case I find that Claimant's condition reached permanency on January 11, 1990, one year after his hip replacement surgery. I base this decision on the testimony of Dr. O'Connell, who specializes in orthopedics. Dr. O'Connell's testimony is the only medical evidence in the record regarding the date of maximum medical improvement. Dr. O'Connell testified that Claimant would reach maximum medical improvement about a year after his surgery.

(CX 7 at 28). Although Dr. O'Connell deferred to the opinion of Dr. Fipp, no such opinion was offered into evidence, therefore Dr. O'Connell's opinion is uncontested and it is held that Claimant's condition reached permanency on January 11, 1990.

Extent of Disability

As Claimant's injury is a non-scheduled injury, he must prove that he has suffered a loss of wage-earning capacity. "Disability" under the LHWCA means incapacity as a result of injury to earn wages which the employee was receiving at the time of injury at the same or any other employment. 33 U.S.C. § 902(10). Therefore, in order for a claimant to receive a disability award, he must have an economic loss coupled with a physical or psychological impairment. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Where the employee's condition is the natural progression of a work-related injury, any compensation awarded is based on the average weekly wage as of the work-related injury. *Merrill*, 25 BRBS at 150.

As discussed *supra*, it has been stipulated that Claimant is not, at this time, seeking total disability benefits. Therefore, Claimant's benefits will be a partial award based upon his wage-earing capacity. Section 8(c)(21) of the Act states:

> In all other cases in the class of disability, the compensation shall be 66 2/3 per centum of the difference between the average weekly wages of the employee and the employee's wage-earning capacity thereafter in the same employment or otherwise, payable during the continuance of partial disability.

33 U.S.C. § 908(c)(21). An additional provision states:

> The wage-earning capacity of an injured employee in cases of partial disability under subdivision (c)(21) of this section or under subdivision (e) of this section shall be determined by his actual earnings if such actual earnings fairly and reasonable represent his wage-earning capacity: Provided, however, That if the employee has no actual earnings or his actual earning do not fairly and reasonably represent his wage-earning capacity, the deputy commissioner may, in the interest of justice, fix such wage-earning capacity as shall be reasonable, having due regard to the nature of his injury, the degree of physical impairment, his usual employment, and any other factors or circumstances in the case which may affect his capacity to earn wages in his disabled condition, including the effect of the disability as it may naturally extend into the future.

33 U.S.C. § 908(h).

In the instant case, as discussed *supra*, Claimant's pre-injury average weekly wage (AWW) was stipulated to be $498.77.[18] (JX 1 at Stip 13). Claimant earned $7.50 per hour starting out with Lockheed in 1988, $8.90 per hour as a "missile mechanic associate" when he

[18] Claimant's income tax returns from 1988-1997 are in evidence at CX 43 and EX 4.

returned after his hip replacement surgery in July of 1989, and was earning $14.84 per hour in 1994 when he developed carpal tunnel syndrom and was fired. (EX 5 at 9). Other factors considered in this case include Claimant's inability to perform most manual labor positions due to his hip condition; his high intelligence and the classes he took while at Lockheed; the fact that he applied for the job with Lockheed well before his injury; and the training period with Lockheed. In addition, the Claimant's post-injury wages should be adjusted according to the yearly national average weekly wage (NAWW). *Richardson v. General Dynamic Corp*., 23 BRBS 327, 330-331(1990).

Although Claimant provided no calculations regarding wage-earning capacity, he has argued that his actual wages do not fairly and accurately reflect his wage-earning capacity. It is assumed that he would argue that the wages earned at the time his condition reached permanency, 1990, *see* discussion *supra*, $22,996 (EX 4 at 3), or AWW $442.23 ($22,996/52), would be the appropriate measure of his wage-earning capacity. Alternatively, Claimant might have argued that his $8.90 per hour wage in 1989 would be the appropriate measure of his loss. If Claimant had worked the entire year, his 1989 AWW would have been $356.00 (8.90 x 40). Even before adjusting by the national average weekly wage, these figures are lower than Claimant's 1987 AWW. Employer contends that Claimant's 1993 wages, wages for the last full year he worked at Lockheed, are the appropriate measure of his wage-earning capacity and that those wages show no loss. (Emp. Reply Brief). Claimant's 1993 average weekly wage would be $615.77 ($32,020/52). The equivalent 1987 value would be $514.56 (369.15/308.48 = 1.1967; $615.77/ 1.1967), which would exceed Claimant's AWW of $498.77 and result in no loss of wage-earning capacity.

Considering Claimant's overall condition, the loss of his ability to be in the Army Reserves, the fact that his future condition will, according to all the medical evidence in the record, deteriorate, and the fact that he is unable to do the manual labor he favored before being injured (army, sheriff, wild life ranger, construction), I find that his 1993 wages showing no loss of wage-earning capacity do not fairly and reasonably represent his wage-earning capacity. On the other hand, Claimant's intelligence, his preference for the job at Lockheed, and his obvious trainability, weigh in favor of finding for the higher wage. Based upon all of these factors, I find that Clamant's wages as of 1992 represent a middle ground and more fairly and reasonably represent Claimant's wage-earning capacity. I will take judicial notice of the fact that the NAWW for October 1, 1992 to September 30, 1993 was $360.57 and the NAWW for October 1, 1987 through September 30, 1988 was $308.48. This results in a percentage increase of 1.689%(360.57/308.48= 1.1689). In 1992 Claimant made $28,520.00. (EX 4 at 5). This computes to an AWW of $548.46 (28,520/52=548.46). Adjusted for inflation using the figure above, the AWW will be $469.17 (548.46 /1.1689=469.17). The difference between his AWW with J.A. Jones ($498.77) and his AWW with Lockheed ($469.17) is $29.60. 66 2/3 per centum of $29.60 is $19.71.

Order

Accordingly, it is hereby ordered that:

1. Employer, J.A. Jones Corporation, is hereby ordered to pay to Claimant, Roland Muse, temporary total disability for January 26, 1988 to February 22, 1988; and January 10, 1989 through July 9, 1989 at the rate of $332.51 per week based upon his stipulated average weekly wage of $498.77;

2. Employer is hereby ordered to pay to Claimant temporary partial disability for the period of February 23, 1988 to January 6, 1989 at the rate of $99.17 per week[19] ;

3. Employer is hereby ordered to pay to Claimant temporary partial disability at the rate of $19.71 per week for the period of July 10, 1989 through January 11, 1990;

4. Employer is hereby ordered to pay to Claimant, permanent partial disability at the rate of $19.71 per week, beginning January 11, 1990 and continuing;

5. Employer is hereby ordered to pay all medical expenses related to Claimant's hip condition;

6. Employer shall receive credit for any compensation already paid;

7. Interest at the rate specified in 28 U.S.C.§ 1961 in effect when this Decision and Order is filed with the Office of the District Director shall be paid on all accrued benefits and penalties, computed from the date each payment was originally due to be paid. See *Grant v. Portland Stevedoring Co.,* 16 BRBS 267 (1984);

8. Claimant's attorney, within 20 days of receipt of this order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

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RICHARD E. HUDDLESTON
Administrative Law Judge

[19]At the hearing, the parties agreed that, if liability is found Claimant would be owed temporary partial disability for this time period based upon his wages of $7.50 per hour while training at Lockheed. (TR. at 27).